No. 85-1763

Supreme Court, U.S.
FILED
APR 24 1986
JOSEPH F. SPANIOL, JR.
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

FLORENCE NIGHTINGALE NURSING HOME,

Petitioner,

—against—

CESAR PERALES, individually and as Commissioner of the New York State Department of Social Services, and GEORGE GROSS, individually and as Administrator/ Commissioner of the New York City Human Resources Administration,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

HOWARD G. KRISTOL
45 Rockefeller Plaza
New York, New York 10111
Telephone: (212) 841-5700

Attorney for Petitioner

WILLIAM DUNNEGAN,
REBOUL, MACMURRAY, HEWITT,
MAYNARD & KRISTOL

Of Counsel.

April 24, 1986

Question Presented

Whether institutional health care providers participating in the Medicaid program must bear the risk of non-payment by Medicaid patients of that portion of the cost of their care for which the patients are legally responsible.

TABLE OF CONTENTS

	PAGE
Question Presented	i
Table of Authorities	v
Opinions Below	2
Jurisdiction	2
Statutes	2
Statement of the Case	2
A. The Structure of Medicaid	2
B. The Parties	3
C. Reimbursement for Uncollectible Debts of Medicaid Patients	3
D. Proceedings in the District Court	5
E. The Ruling of the District Court	5
F. The Ruling of the Court of Appeals	6
Reasons for Granting the Writ	7
I. This Case Raises a Significant and Recurring Issue Concerning the Right of Institutional Health Care Providers to Reimbursement Under the Medicaid Statutes.	8
II. The Decision of the Court of Appeals Was Patently Erroneous.	9
III. The Decision of the Court of Appeals Conflicts in Principle With a Decision of the Tenth Circuit.	15
Conclusion	16

PAGE

Appendix A A-1

Appendix B B-1

Appendix C C-1

Appendix D D-1

Appendix E E-1

Appendix F F-1

PAGE

TABLE OF AUTHORITIES

Cases

DeJesus v. *Perales*, 770 F.2d 316 (2d Cir. 1985) 6

Florida Department of Health and Rehabilitative Services v. *Florida Nursing Home Ass'n*, 450 U.S. 147 (1981) 9-10

Friedman v. *Berger*, 547 F.2d 724 (2d Cir. 1976), *cert. denied*, 430 U.S. 984 (1977) 6, 11-12

James v. *Harris*, 499 F. Supp. 594 (M.D. Ala. 1980), *aff'd on opinion below*, 650 F.2d 814 (5th Cir. 1981) 12

Seneca Nursing Home v. *Secretary of Social and Rehabilitation Services*, 604 F.2d 1309 (10th Cir. 1979) 7-8, 15

Southeastern Community College v. *Davis*, 442 U.S. 397 (1979) 14

Statutes

Title XVI of the Social Security Act 15
Title XIX of the Social Security Act 2, 15
28 U.S.C. § 1254(1) 2
28 U.S.C. § 1331 5
42 U.S.C. § 1381 15
42 U.S.C. § 1395f(b) 12
42 U.S.C. § 1396 .....2, 3, 15
42 U.S.C. § 1396a(a)(13)(A) 2, 10, 13
42 U.S.C. § 1396a(a)(13)(E) (former provision). 6, 9, 10
86 Stat. 1426 9

PAGE

Regulations

42 C.F.R. § 405.420 12-13
42 C.F.R. § 435.725 4
42 C.F.R. § 435.832 4

Other Authorities

S. Rep. No. 1230, 92d Cong., 2d Sess. 287-288 (1972) 2, 9, 11, 13

New York State Department of Social Services, Docket No. 81-161 NY-HC, Decision No. 284; (Dep't of Health & Human Services Grant Appeals Board, August 29, 1982) 14

United States Department of Health and Human Services, Social Security Administration, *Social Security Bulletin, Annual Statistical Supplement 1984-85,* ISSN 0037-7910 8

IN THE

Supreme Court of the United States

October Term, 1985

No. 85-

FLORENCE NIGHTINGALE NURSING HOME,

Petitioner,

—against—

CESAR PERALES, individually and as Commissioner of the New York State Department of Social Services, and GEORGE GROSS, individually and as Administrator/ Commissioner of the New York City Human Resources Administration,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

Petitioner Florence Nightingale Nursing Home ("Florence Nightingale") respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Second Circuit, entered January 24, 1986, which (a) reversed a judgment of the United States District Court for the Southern District of New York, (b) vacated an injunction entered by that District Court and (c) held that Florence Nightingale was not entitled to be reimbursed by respondents for the debts owed to it by certain Medicaid patients for skilled nursing services which Florence Nightingale was unable to collect from the patients.

Opinions Below

The opinion of the Court of Appeals is reported at 782 F.2d 26 (2d Cir. 1986). A copy is annexed as Exhibit A. The opinion of the District Court which granted Florence Nightingale's motion for partial summary judgment is not reported. A copy is annexed as Appendix B. An earlier opinion of the District Court, upon which its decision granting summary judgment was based, is reported at 570 F. Supp. 285 (S.D.N.Y. 1983). A copy is annexed as Appendix C.

Jurisdiction

The judgment of the Court of Appeals was dated and entered January 24, 1986. A copy is annexed as Appendix D. This petition is filed pursuant to 28 U.S.C. § 1254(1), within the time allowed by law.

Statutes

The statutory provision involved in this action is 42 U.S.C. § 1396a(a)(13)(A). A copy is annexed as Appendix E. A relevant portion of the legislative history of that statute, S. Rep. No. 1230, 92d Cong., 2d Sess. 287-288 (1972), is annexed as Appendix F.

Statement of the Case

A. The Structure of Medicaid

In 1965, Congress established Medicaid under Title XIX of the Social Security Act to provide medical assistance to the needy. *See* 42 U.S.C. § 1396 *et seq.* Under the Medicaid program, the federal government provides money to participating states to reimburse hospitals, nursing homes and other health care providers for costs they incur in providing services to eligible Medicaid recipients. In turn,

the Medicaid statutes provide that each participating state must create a plan describing its administrative procedures and file that plan with the United States Department of Health and Human Services ("HHS"). The plan established by each state must comply with federal law.

B. The Parties

Respondent Cesar Perales is the Commissioner of the New York State Department of Social Services (the "State"), the state agency responsible for administering the Medicaid program in New York State. At all relevant times, New York State has participated in the Medicaid program.

Respondent George Gross is the Administrator/Commissioner of the New York City Human Resources Administration (the "City"). The City acted as the agent of the State in administering the Medicaid program in New York City from January 1, 1976, until December 1, 1978.

Florence Nightingale is a licensed nursing home located in New York, New York. Pursuant to an agreement with the State, Florence Nightingale provides skilled nursing services to Medicaid patients.[1] Florence Nightingale receives reimbursement for those services pursuant to the Medicaid statutes, 42 U.S.C. § 1396 *et seq.* Florence Nightingale provides its services to approximately 1,400 Medicaid recipients each year.

C. Reimbursement for Uncollectible Debts of Medicaid Patients

Florence Nightingale's claims in this action involve an issue common to many, if not all, institutional health care

---

[1] None of the parties to this action is a corporation. None has, therefore, corporate parents, subsidiaries or affiliates.

providers in the United States which participate in the Medicaid program. Under federal law, a state participating in the Medicaid program may require a Medicaid patient whose income is above a certain level to pay the provider for a portion of the cost of his or her care. In New York, the Medicaid patient's contribution to the cost of care is termed "Net Available Monthly Income," or N.A.M.I. N.A.M.I. represents the gross income of the Medicaid patient, including pension and social security benefits, minus the patient's "personal needs allowance." *See* 42 C.F.R. §§ 435.725, 435.832. Other states also require Medicaid patients to contribute a portion of their income to the overall cost of their care.

The parties agreed below that, if a Medicaid patient pays the required amount to the provider, or if the provider fails to make a reasonable effort to collect it from the patient, the provider is not entitled to reimbursement from the State for any uncollected amount. The issue presented in this action arises when the Medicaid patient fails or refuses to satisfy his or her obligation to pay the required amount to the provider, and the provider cannot, despite the exercise of reasonable efforts, collect the amount due from the patient.

Over the years, the State has taken inconsistent positions with respect to its obligation to reimburse providers, such as Florence Nightingale, for uncollectible N.A.M.I. Prior to July 2, 1979, the State recognized its obligation to reimburse providers for a Medicaid recipient's N.A.M.I. which the provider could not collect. On July 2, 1979, the State announced retroactively that, effective June 1978, it would not reimburse Florence Nightingale or other Medicaid providers for uncollectible N.A.M.I.

D. Proceedings in the District Court

Florence Nightingale commenced this action on October 16, 1980, pursuant to 28 U.S.C. § 1331, challenging the validity of the change in the State's reimbursement policy. Florence Nightingale sought, among other things, declaratory and injunctive relief which, if granted, would require the State and the City to continue to reimburse Florence Nightingale and other Medicaid providers for uncollectible N.A.M.I.

The State moved to dismiss Florence Nightingale's claims by notice of motion returnable December 12, 1980. By opinion dated July 27, 1983 (reported at 570 F. Supp. 285), and order entered October 11, 1983, the District Court denied the State's motion to dismiss and held, among other things, that Florence Nightingale had stated a valid claim under the Medicaid statutes for reimbursement of the uncollectible amounts due from Medicaid patients.

E. The Ruling of the District Court

By notice of motion dated November 16, 1984, Florence Nightingale moved for summary judgment on its claim for reimbursement for uncollectible N.A.M.I. By endorsed memorandum dated July 12, 1985, the District Court granted the motion insofar as it sought declaratory and injunctive relief. In reliance upon its prior opinion reported at 570 F. Supp. 285, the District Court held that the Medicaid statutes require the State and City to reimburse Florence Nightingale for the reasonable costs of providing patient services, including that portion of the costs represented by uncollectible patients' N.A.M.I. The District Court entered judgment on September 13, 1985, and the State and City thereafter filed timely notices of appeal.

F. The Ruling of the Court of Appeals

In its opinion, based largely upon an *amicus* brief filed by HHS, the Court of Appeals reversed the judgment of the District Court, reasoning as follows:

> During the relevant time period, section 1396a (a)(13)(E) required a state plan to provide for 'payment of the skilled nursing facility and intermediate care facility *services provided under the plan* on a reasonable cost basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of the cost findings methods approved and verified by the Secretary . . .' (emphasis added). The District Court determined that the statute 'clearly calls for a cost-based reimbursement program.' 570 F. Supp. at 288. But the District Court did not reckon with the fact that 'reasonable cost basis' applies only to the cost of 'services provided under the plan.' In authorizing reimbursement of providers for Medicaid care costs, Congress clearly intended *not* to reimburse for costs not covered by Medicaid. NAMI represents the amount that a patient is required to contribute toward his or her care. This contribution reduces the amount that the patient is eligible to have paid on his or her behalf under the Medicaid program. *See Friedman* v. *Berger,* 547 F.2d 724, 726-27 (2d Cir. 1976), *cert. denied,* 430 U.S. 984, 97 S.Ct. 1681, 52 L.Ed.2d 378 (1977). It is arguable that NAMI payments remaining uncollected despite reasonable collection efforts are an overhead cost reimbursable like all other costs of providing covered services. But the Secretary's view, expressed in an amicus brief, that uncollected NAMI is not reimbursable is the more reasonable interpretation and is entitled to 'particular deference.' *DeJesus* v. *Perales,* 770 F.2d 316, 327 (2d Cir. 1985).

782 F.2d at 28-29 [A-4-5] (emphasis in original; footnote omitted).

Reasons for Granting the Writ

This case presents an important question of federal law which affects not only Florence Nightingale, but also all other institutional health care providers throughout the United States which are unable to collect the debts owed them by Medicaid patients for that portion of the overall cost of their care for which the patients are responsible under the Medicaid statutes.

The Court of Appeals' decision not only tortures the language of the governing statute, but is flatly inconsistent with the intent of Congress to compensate Medicaid providers for the costs incurred in providing services to Medicaid patients. By ruling that health care providers are not entitled to reimbursement for the uncollectible debts of Medicaid patients, the Court of Appeals has, in effect, made the provider the guarantor, and ultimate payor, of a portion of the overall cost of a patient's care. If permitted to stand, the Second Circuit decision will (a) undermine the financial ability of providers to provide an appropriate level of care to Medicaid patients and (b) cause providers to decline admission to those Medicaid patients whom they perceive to represent an undue credit risk. In enacting the Medicaid statutes, Congress did not intend that providers themselves bear a portion of the cost of a patient's care, nor did it intend that creditworthiness be a factor in the provider's determination to admit or reject a patient otherwise eligible for Medicaid assistance.

The decision of the Court of Appeals also requires review, because it conflicts, at least in principle, with the decision of the Court of Appeals for the Tenth Circuit in *Seneca Nursing Home* v. *Secretary of Social and Rehabilita-*

tion Services, 604 F.2d 1309 (10th Cir. 1979). There, the Court of Appeals, in partial reliance upon the federal Medicaid laws, ruled that nursing homes were entitled to reimbursement from the state agency for uncollectible patient contributions.

Given the importance of this issue to institutional health care providers and patients, the degree to which the decision of the Court of Appeals conflicts with the language and intent of the Medicaid statutes and the apparent conflict with a prior decision of another Court of Appeals, this Court should grant this petition for a writ of certiorari.

I.

This Case Raises a Significant and Recurring Issue Concerning the Right of Institutional Health Care Providers to Reimbursement Under the Medicaid Statutes.

The resolution of the issue presented in this case will affect every hospital, nursing home and intermediate care facility that participates in the Medicaid program and is unable to collect the full amount of the statutorily-mandated indebtedness owed to them by each of their Medicaid patients. According to HHS, there are more than 21,000 of these institutions in the United States,[2] which provide services to more than 5,000,000 Medicaid patients.[3]

Although it cannot be calculated with mathematical certainty, the amount of money at stake in this controversy is

---

[2] This information is set forth in a computer printout created by HHS, dated March 31, 1986, entitled "Provider Count Table."

[3] *See* United States Department of Health and Human Services, Social Security Administration, *Social Security Bulletin, Annual Statistical Supplement, 1984-85*, ISSN 0037-7910, Table 153, p. 220.

substantial. In the District Court, Florence Nightingale sought recovery of an average of more than $24,000 per year of uncollectible patient debt. If the uncollectible debt of each of the more than 21,000 Medicaid providers throughout the United States was just five percent of the indebtedness that Florence Nightingale was unable to collect, *i.e.*, $1,200 per year, the total amount of such indebtedness would be more than $25,200,000 per year.[4] The issue presented in this case is important, merits more than the superficial analysis and summary disposition afforded by the Court of Appeals and requires a definitive adjudication by this Court.

II.

The Decision of the Court of Appeals Was Patently Erroneous.

In 1972, Congress amended the Medicaid statutes to require participating states to reimburse health care providers for services they provide to Medicaid patients on a "cost related basis." 86 Stat. 1426, 42 U.S.C. § 1396a(a)(13)(E). Congress intended that this section would eliminate "flat rate" reimbursement systems that had been used by some states, which tended to compensate providers unfairly for the cost of the services they provided to Medicaid patients. S. Rep. No. 1230, 92d Cong., 2d Sess. 287-288 (1972). *See generally Florida Department of Health and*

[4] The State advised the District Court by letter dated August 14, 1985, that for the fiscal year 1983-1984 health care facilities in New York State reported N.A.M.I. of $300,000,000. Florence Nightingale estimates that approximately three percent of its N.A.M.I. is uncollectible. Thus, if other Medicaid providers in New York State experience the same percentage of uncollectible N.A.M.I. as does Florence Nightingale, approximately $9,000,000 would be involved with respect to providers located in New York State alone.

Rehabilitative Services v. *Florida Nursing Home Ass'n*, 450 U.S. 147 (1981).

In 1980, § 1396a(a)(13)(E) was replaced by the present § 1396a(a)(13)(A), which provides in relevant part:

> A State plan for medical assistance must—
>
> * * *
>
> (13) provide—
>
> (A) for payment . . . of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates . . . which the State finds . . . are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards . . . .

The State and City conceded below that this 1980 amendment did not alter the substance of the former provision for purposes of this case.

Florence Nightingale contends that, under 42 U.S.C. § 1396a(a)(13)(A), it is entitled to be fully reimbursed, on a reasonable and adequate cost basis, for the costs it incurs in providing services to Medicaid patients. Under the Medicaid statutes, it cannot be compelled by the State to be either a payor, or a guarantor of payment, of any portion of the cost of those services. Unless Florence Nightingale is reimbursed for that portion of the cost of care that it is unable, after reasonable efforts, to collect from its patients, it will be deprived of full reimbursement of its costs in contravention of those statutes. The District Court agreed and entered judgment accordingly. The Court of Appeals, basing its decision on three grounds,

rejected the District Court's interpretation of the governing statute.

First, the Court of Appeals said, uncollectible debts of Medicaid patients do not result from "services provided under the plan." [A-4] That ruling contorts the plain language of the statute. The phrase "services provided under the plan" was intended to prevent reimbursement for "luxury" or similar services, which are not at issue here. S. Rep. No. 1230, 92d Cong., 2d Sess. 287-288 (1972). There is no indication that that phrase was intended to diminish reimbursement to the provider of its overall out-of-pocket costs simply because the Medicaid patient was obliged by law to pay a portion of those costs. The Court of Appeals' reading of the statute simply begs the question.

Second, the Court of Appeals ruled, in effect, that uncollectible debts of Medicaid patients are not "costs." [A-4] That ruling too is plainly erroneous. When Florence Nightingale provides nursing services to a patient, it incurs costs, whether for labor, materials or both. It then bills the State for a portion of those costs and seeks to recover the balance from the patient in the form of the patient's N.A.M.I. If Florence Nightingale cannot collect from the patient that portion of the total cost of care that the patient is obligated to pay, that portion may become a "bad debt," but it still represents a cost. The Court of Appeals' contrary conclusion is patently erroneous.

Third, the Court of Appeals ruled, the view expressed by HHS in an *amicus* brief, namely, "that uncollected NAMI is not reimbursable is the more reasonable interpretation," was entitled to " 'particular deference.' " [A-4-5] The Second Circuit has recognized that, "[a]s program after program has evolved, there has developed a degree of complexity in the Social Security Act and particularly the

regulations which make them almost unintelligible to the uninitiated." *Friedman* v. *Berger*, 547 F.2d 724, 727 n.7 (2d Cir. 1976), *cert. denied*, 430 U.S. 984 (1977). Given that complexity, the Court of Appeals looked to HHS to proffer a proper reading of the Medicaid statutes. Its deference to the view of HHS in this case, however, though understandable, was entirely unwarranted.

The regulations adopted by HHS with regard to uncollectible patient debts are fundamentally inconsistent with the basic purpose of the Medicaid statutes. In *James* v. *Harris*, 499 F. Supp. 594 (M.D. Ala. 1980), *aff'd on opinion below*, 650 F.2d 814 (5th Cir. 1981), the district court said:

> It is clear that the purpose of the Social Security Act and the regulations formulated thereunder is for the cost of nursing care to be shared by the patient, the state, and the federal government.

499 F. Supp. at 597. It is not the purpose of the Medicaid statutes—indeed, it is contrary to the purpose of those statutes—to require providers to share in the cost of patient care. The interpretation of those statutes by HHS, which would require providers to absorb the uncollectible debts of Medicaid patients, is therefore utterly inconsistent with the language and basic purpose of the Medicaid statutes.

The interpretation of HHS is also inconsistent with the relationship Congress intended to achieve with respect to the reimbursement of providers under the Medicare and Medicaid programs. Under the Medicare statutes, a provider of health care services is entitled to reimbursement for the "reasonable cost of such services." 42 U.S.C. § 1395f(b). Pursuant to those statutes, HHS promulgated 42 C.F.R. § 405.420, which states:

> (a) *Criteria for allowable bad debt.* A bad debt must meet the following criteria to be allowable:
>
> (1) The debt must be related to covered services and derived from deductible and co-insurance amounts.
>
> (2) The provider must be able to establish that reasonable collection efforts were made.
>
> (3) The debt was actually uncollectable when claimed as worthless.
>
> (4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

Under the Medicare program, therefore, HHS recognizes that providers, under appropriate circumstances, are to be reimbursed for uncollectible debts of patients.

In 1972, Congress authorized the states, at their option, to reimburse Medicaid providers in the same manner as Medicare providers. The Senate Report which preceded enactment of the 1972 amendments to the Medicaid statutes stated:

> [T]he committee does not intend that this provision [the predecessor of 42 U.S.C. § 1396a(a)(13)(A)] should require use of the specific medicare reasonable cost reimbursement formula by States for purposes of reimbursing skilled nursing homes and intermediate care facilities under medicaid, *although States are free to choose this option.*"

S. Rep. No. 1230, 92d Cong., 2d Sess. 287 (1972) [F-1-2] (emphasis added). Inasmuch as (a) a provider would be entitled under Medicare to be reimbursed for the kind of uncollectible patient debts involved in this case and (b) Congress authorized states to reimburse providers for their costs under Medicaid in the same manner as under Medi-

care, the position of HHS that the Medicaid statutes prohibit reimbursement for the uncollectible debts of Medicaid patients is plainly wrong.[5]

Because HHS has adopted regulations that are flatly inconsistent with the purpose and intent of the Medicaid statutes, its interpretation of the governing statute is entitled to no deference whatsoever. As this Court stated in *Southeastern Community College* v. *Davis*, 442 U.S. 397 (1979):

> Although an agency's interpretation of the statute under which it operates is entitled to some deference, this deference is constrained by our obligation to honor the clear meaning of a statute, as revealed by its language, purpose, and history.

442 U.S. at 411 (citation omitted). In this case, the Court of Appeals erred in adopting an interpretation of the Medicaid statutes that is contrary to both the language and the purpose of those statutes. Review by this Court is necessary, therefore, to compel compliance by federal and state authorities with the plain meaning and intent of the statutes involved.

---

[5] The apparent reason for this inconsistency is that HHS developed its views not contemporaneously with the enactment of the statute, but in response to the events which gave rise to this litigation. Although the relevant portion of the statute was enacted in 1972, it was not until August 29, 1982, when the HHS Grant Appeals Board decided *New York State Department of Social Services*, Docket No. 81-161 NY-HC, Decision No. 284, that HHS officially articulated its position that providers were not entitled to reimbursement for the uncollectible N.A.M.I. owed them by their Medicaid patients. The Grant Appeals Board based its decision not on the language or legislative history of the Medicaid statutes, but on the language of the Medicaid regulations. Thus, in the present case, the views expressed by HHS in its *amicus* brief in the Court of Appeals were nothing more than self-serving conclusions, following an adverse decision in the District Court, based solely upon the language of regulations it had prepared and adopted.

III.

The Decision of the Court of Appeals Conflicts in Principle With a Decision of the Tenth Circuit.

In *Seneca Nursing Home* v. *Secretary of Social and Rehabilitation Services,* 604 F.2d 1309 (10th Cir. 1979), the Court of Appeals for the Tenth Circuit ruled that nursing homes were entitled to reimbursement from the State of Kansas for uncollectible debts owed them by Medicaid patients. Although the Tenth Circuit rendered its decision on the basis of a Kansas statute, it stated:

> In so holding we are influenced by the fact the Federal Social Security Act sections involved, 42 U.S.C. §§ 1381 *et seq.* (Title XVI) and 42 U.S.C. §§ 1396 *et seq.* (Title XIX), provide federal grants to carry at least a major portion of the medical and other care for these individuals.

604 F.2d at 1315. It is apparent that the Tenth Circuit holds a view with respect to the obligation of a state to reimburse providers for uncollectible patient debts that is contrary to the decision of the Second Circuit. This Court should therefore review the judgment rendered below to resolve that conflict.

Conclusion

The issue presented here has nationwide significance. Reimbursement of providers under the Medicaid program for the full cost of patient care should turn not upon geography, but upon the language and intent of the governing federal statutes. Only by a review of the judgment below can this Court assure a uniform national result. For the foregoing reasons, this Court should issue a writ of certiorari to the United States Court of Appeals for the Second Circuit.

April 24, 1986

Respectfully submitted,

HOWARD G. KRISTOL
45 Rockefeller Plaza
New York, New York 10111
Telephone: (212) 841-5700

Attorney for Petitioner

WILLIAM DUNNEGAN,
REBOUL, MACMURRAY, HEWITT,
MAYNARD & KRISTOL
45 Rockefeller Plaza
New York, New York 10111
Telephone: (212) 841-5700

Of Counsel.

APPENDIX A

Florence Nightingale Nursing Home v. *Cesar Perales, individually and as Commissioner of the New York State Department of Social Services, and George Gross, individually and as Administrator/Commissioner of the New York City Human Resources Administration*

782 F.2d 26 (2d Cir. 1986)

UNITED STATES COURT OF APPEALS

SECOND CIRCUIT

Nos. 585, 586—August Term 1985

Argued: December 12, 1985—Decided: January 24, 1986

Docket Nos. 85-7755, 85-7759

FLORENCE NIGHTINGALE NURSING HOME,

Plaintiff-Appellee,

v.

CESAR PERALES, individually and as Commissioner of the New York State Department of Social Services, and George Gross, individually and as Administrator/Commissioner of the New York City Human Resources Administration,

Defendants-Appellants.

Before:

KAUFMAN, TIMBERS and NEWMAN,

Circuit Judges.

JON O. NEWMAN,

Circuit Judge:

The issue on this appeal is whether losses resulting from non-payment of money owed by Medicaid patients, despite reasonable collection efforts, are to be borne by the medical care providers to whom the money is owed or are to be reimbursed out of public funds. The State of New York and the City of New York appeal from a judgment of the District Court for the Southern District of New York (Richard Owen, Judge) granting appellee Florence Nightingale Nursing Home ("Nightingale") partial summary judgment and enjoining the State and City from refusing to

reimburse Nightingale for amounts owing from Medicaid patients. Appellants contend that the District Court's decision was incorrect because the reimbursement Nightingale seeks is prohibited by federal statutes and regulations. The State also argues that it should have been allowed to implead the Department of Health and Human Services ("HHS"). Because we agree with appellants' view of federal law, we reverse the reimbursement order and need not reach the third-party issue.

BACKGROUND

New York State is a participant in the Medicaid program, Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, which provides federal financial assistance to states that choose to pay certain medical expenses of the needy. Every state that participates must submit a plan describing its medical assistance program. Upon approval of its plan by the Secretary of HHS, the state becomes eligible for partial federal reimbursement of expenditures made in accordance with the approved plan. Individuals eligible for Medicaid do not receive direct payments for their medical expenses. Instead, the institution providing care bills the state, at rates established by the state, for allowable Medicaid care costs incurred and obtains reimbursement. The state in turn bills the Health Care Financing Administration of HHS, which then reimburses the state at the specified federal financial participation rate (50 percent in New York).

Medicaid recipients who are admitted to nursing homes and who have income exceeding a specified level must pay for a portion of their care. The amount to be paid by the patient is determined by subtracting from the patient's income a relatively low "personal needs allowance." Under New York State's medical assistance program, the amount

that remains is referred to as "net available monthly income" or "NAMI." [1] Between July 1, 1976, and July 2, 1979, the State imposed the initial burden of collecting NAMI on institutional providers such as Nightingale but permitted resubmission of bills when providers were unable to collect the funds due. In those cases, the State [2] paid the providers the amounts of uncollected NAMI. The State then changed its policy, advising providers that they and not the State would be responsible for unpaid NAMI. This change was retroactive, effective June 1978.

Nightingale sued, seeking to enjoin the State from refusing to reimburse it for NAMI it claims is owing and uncollectible from Medicaid patients. The District Court denied the State's motion to dismiss the action, *Florence Nightingale Nursing Home* v. *Blum,* 570 F.Supp. 285 (S.D.N.Y. 1983), and later granted Nightingale partial summary judgment on the ground that the federal statutory and regulatory scheme requires states participating in the Medicaid program to bear the risk of patient non-payment. The State and City appealed the ensuing injunction ordering prospective reimbursement. The claim for retrospective reimbursement remains pending.

DISCUSSION

The District Court's reasoning, expressed in its ruling on the motion to dismiss, is that 42 U.S.C. § 1396a(a)(13)(E), 42 C.F.R. § 447.15, and *Seneca Nursing Home* v. *Secretary of Social and Rehabilitation Services of Kansas,*

---

[1] The federal regulations refer to this as "[a]pplication of patient income to the cost of care," 42 C.F.R. §§ 435.725, 435.832 (1984).

[2] Prior to December 1, 1978, the New York State Department of Social Services delegated to the New York City Human Resources Administration the task of receiving and evaluating claims by New York City nursing homes for services rendered to New York City residents.

604 F.2d 1309 (10th Cir. 1979), support the conclusion that institutional providers have a right to reimbursement from the State for uncollectible NAMI. We disagree.

During the relevant time period, section 1396a(a)(13)(E) required a state plan to provide for "payment of the skilled nursing facility and intermediate care facility *services provided under the plan* on a reasonable cost basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of the cost finding methods approved and verified by the Secretary . . ." [3] (emphasis added). The District Court determined that the statute "clearly calls for a cost-based reimbursement program." 570 F.Supp. at 288. But the District Court did not reckon with the fact that "reasonable cost basis" applies only to the cost of "services provided under the plan." In authorizing reimbursement of providers for Medicaid care costs, Congress clearly intended *not* to reimburse for costs not covered by Medicaid. NAMI represents the amount that a patient is required to contribute toward his or her care. This contribution reduces the amount that the patient is eligible to have paid on his or her behalf under the Medicaid program. *See Friedman* v. *Berger*, 547 F.2d 724, 726-27 (2d Cir. 1976), *cert. denied*, 430 U.S. 984, 97 S.Ct. 1681, 52 L.Ed.2d 378 (1977). It is arguable that NAMI payments remaining uncollected despite reasonable collection efforts are an overhead cost reimbursable like all other costs of providing covered services. But the

---

[3] Section 1396a(a)(13)(E) was amended in 1980 and was replaced by the present section 1396a(a)(13)(A), which requires that state plans provide for payment to providers based on "rates . . . which the State finds . . . are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . . ." Pub. L. No. 96-499, § 962(a) (1980). *See also* Pub. L. No. 97-35, § 2173(a)(1)(C) (1981) (renumbering subsections).

Secretary's view, expressed in an amicus brief, that uncollected NAMI is not reimbursable is the more reasonable interpretation and is entitled to "particular deference." *DeJesus* v. *Perales*, 770 F.2d 316, 327 (2d Cir. 1985).

This reading of the statute is plainly supported by the federal regulations, which make clear that state Medicaid agencies may not pay institutions any amounts that are the patient's responsibility. The regulations state that "[t]he agency must reduce its payment to an institution, for services provided to an individual . . . , by the amount that remains after deducting the amounts specified in paragraph (c) of this section [*i.e.*, the individual's personal needs allowance], from the individual's income." 42 C.F.R. §§ 435.725, 435.832 (1984). The regulations are consistent with the statutory plan that Medicaid funds not be paid to reimburse those costs that patients with resources of their own can afford.

The regulatory scheme is not altered by 42 C.F.R. § 447.15. According to section 447.15, "[a] State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency . . . ." The District Court construed this to mean that states rather than providers should be the guarantors of payment. 570 F. Supp. at 288. This interpretation is inconsistent with both the statute and the other regulations. Section 447.15 does not discuss the agency's purported responsibility to the provider for costs of care that are the patient's responsibility. It simply prevents providers from seeking contributions from patients beyond the limits set by Medicaid.

Nor does *Seneca Nursing Home, supra*, cited by the District Court, aid the appellee. In that case, the Tenth Circuit held that a Kansas statute required the state agency to reimburse medical providers for uncollected patient contribu-

tions. 604 F.2d at 1314-15. As we have stated, 42 U.S.C. § 1396a(a)(13)(E) required payment by the state only of the cost of services covered by Medicaid. The statute was silent on the consequences of a state's decision voluntarily to reimburse providers for costs not covered by Medicaid, such as patients' NAMI. However, nothing in *Seneca Nursing Home* permits a state that makes such voluntary reimbursement to receive federal reimbursement for such payments. In any event, there is no New York statute analogous to the Kansas statute in *Seneca Nursing Home*.

CONCLUSION

Both the statute and the regulations make clear that the financial responsibility for patient NAMI is not borne by the Medicaid program. The burden of uncollectible NAMI does not fall on the city, state, or federal government but rather on the institutional provider. The judgment of the District Court is reversed, the injunction is vacated, and the cause is remanded with directions to enter judgment for the defendants.

APPENDIX B

Florence Nightingale Nursing Home v. *Cesar Perales, individually and as Commissioner of the New York State Department of Social Services, and George Gross, individually and as Administrator/Commissioner of the New York City Human Resources Administration*

— F. Supp. — (S.D.N.Y. 1985)

NIGHTINGALE

v.

PERALES,

80 Civ. 5899 (RO)

ENDORSED MEMORANDUM

The motion for summary judgment is granted as to items (i)(a) and (b) for reasons already fully articulated in my prior opinion at 570 F.Supp. 285 which reasoning I have completely reviewed.

It seems to me that where the state proposes to pay to a provider virtually all of a recipient's costs, the provider is not in the same unfettered position to reject any recipient for credit reasons as it would have been were the recipient to be paying all of the costs personally. In the latter situation, a nursing home can make up its own mind as to whether or not it chooses to accept the credit risk involved. It seems to me that the right to reject a recipient-patient becomes illusory where the state has committed itself to pay virtually all the cost. Thus as between the provider and the state, I deem it the state's responsibility to stand behind the credit risk. See Fn. 2 of my prior opinion in accord, 570 F.Supp. at 289, setting forth the legislative history which envisions that the provider will be paid in full when it undertakes to serve a needy recipient.

I am aware that there are federal regulations (see 42 C.F.R. §§ 435.725(a), 435.832, 435.852(a), 435.1002 (b), and 435.733) which are inconsistent with the view I have taken. I remain unpersuaded that Congress intended the provider to have to risk potentially crippling credit losses attendant upon providing services to needy recipients that the state tenders as almost completely funded.

Summary judgment is denied as to item (i)(c) since there are issues as to the amount and nature of the back bills. The parties are to appear before me on September 13, 1985 at 12:45 p.m., Courtroom 128 to set a day for trial of said open issues. Submit order on notice.

Dated: New York, New York
July 12, 1985

/s/ RICHARD OWEN

.....
United States District Judge

APPENDIX C

Florence Nightingale Nursing Home v. *Cesar Perales, individually and as Commissioner of the New York State Department of Social Services, and George Gross, individually and as Administrator/Commissioner of the New York City Human Resources Administration*

570 F. Supp. 285 (S.D.N.Y. 1983)

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

July 27, 1983

No. 80 Civ. 5899 (RO)

FLORENCE NIGHTINGALE NURSING HOME,

Plaintiff,

v.

BARBARA B. BLUM, individually and as Commissioner of the New York State Department of Social Services, *et al.*,

Defendants.

OPINION AND ORDER

OWEN, District Judge.

Plaintiff Florence Nightingale Nursing Home ("Nightingale") is a duly licensed, skilled nursing facility and provider of medical services, and a participant in the federal Medicaid program, 42 U.S.C. § 1396, *et seq.* Defendant Barbara B. Blum (the "State") is the Commissioner of the New York State Department of Social Services. Defendant Stanley Brezenoff (the "City") is the Administrator/Commissioner of the New York City Human Resources Administration. From January 1, 1976 until December 1, 1978, the New York City Human Resources Administration acted as the administering agent of the Medicaid program within its jurisdiction pursuant to the State's delegation of author-

ity.[1] For the remainder of the period covered by plaintiff's complaint, the State directly administered the program. The legal liability of the State for actions taken by the City during its period of administration is at issue in this action.

Plaintiff's claims arise from its participation as a provider of medical services in the Medicaid program. Under that program the federal government allocates funds to participating states in order that those states may channel the allocated monies to provide health care for qualifying individuals. Among the specific uses to which Medicaid money is applied is the reimbursement of certain health-related facilities ("providers") for costs incurred by them in servicing the medical needs of individuals qualified to receive assistance under the program ("recipients").

New York State participates in the Medicaid program. Nightingale participates in the program as a provider and is party to a contractual agreement with the State, known as a Provider Agreement, which together with the federal statute and regulations sets the terms of the relationship between the State and Nightingale. Nigthingale, in this action, has sought relief against the State on both contractual and statutory grounds.

At the heart of plaintiff's complaint are two contentions which raise questions under the reimbursement portions of the statute and Provider Agreement. First, plaintiff com-

---

[1] Plaintiff has named both the City and the State as defendants on its claims. Initially, the City filed cross-claims against the State alleging that the State should be ultimately liable on any damages which it—the City—was found to owe plaintiff. On April 28, 1983, those cross-claims were settled. Plaintiff is still asserting its claims against both the City and the State. Nevertheless, because the State's contentions on this motion are largely jurisdictional in nature, the apportionment of liability as between the State and the City is not before me at this time. I therefore will discuss the present motion by referring only to the State except where it is necessary to differentiate between the two.

plains that the State, in contravention of its statutory and contractual duties, has left it to bear the cost of the residual liabilities that arise when a recipient of Medicaid benefits, who is also personally liable for part of the cost of medical services, fails to make good on this debt. As a corollary to this claim, plaintiff asserts that the State has left it with the burden and cost of collecting these obligations. Second, plaintiff contends that both the City and State defendants have wrongfully refused to pay on duly submitted bills for services it provided to qualifying Medicaid recipients.

Now before me is the motion of the State defendant to dismiss this action, in whole or in part. It contends (1) that subject matter jurisdiction is lacking; (2) that the Eleventh Amendment prohibits federal district courts from taking jurisdiction of so much of plaintiff's action as seeks the retroactive payment of state funds, *e.g.*, *Edelman* v. *Jordan*, 415 U.S. 651, 94 S.Ct. 1347, 39 L.Ed.2d 662 (1974); and (3) that even if federal subject matter jurisdiction attaches, plaintiff has failed to state a claim.

Plaintiff's complaint raises complex questions of federal statutory interpretation. Plaintiff, in sum, is seeking a declaration from the Court to the effect that the State defendant is not administering its Medicaid program in conformity with the guidelines set forth by the Medicaid statute, *supra*. Having raised issues pursuant to that statute, the Supremacy Clause of the United States Constitution, and § 1983, plaintiff's federal claims have jurisdictional basis under 28 U.S.C. § 1343. *Cf. Seneca Nursing Home* v. *Kansas State Board of Social Welfare*, 490 F.2d 1324 (10th Cir. 1974) at 1328 (wherein the Court of Appeals considered whether jurisdiction lay to hear an analogous question of law and concluded that the "claims of conflict between the Kansas [State Plan] and the federal statutes . . . are not so wholly insubstantial that federal jurisdiction does not exist.")

Jurisdiction of plaintiff's complaint is barred to the extent that the Eleventh Amendment prohibits the prosecution of suits seeking the retroactive payment of state funds in the federal courts. *Edelman* v. *Jordan, supra.*

Upon this record, however, it is unclear whether the State will be ultimately liable for total, partial, or any reimbursement or whether such reimbursement is, in fact, chargeable to federal or city funds. Therefore, the State's motion to dismiss on Eleventh Amendment grounds is denied at this time without prejudice to its renewal at a later time upon a more complete record.

Turning to the substantive claims, I find that Nightingale has adequately pleaded claims for relief. The State first contests the so-called N.A.M.I. reimbursement procedure. Certain recipients of Medicaid, although eligible for some assistance under the program, also have financial assets of their own. These assets have been termed Net Available Monthly Income ("N.A.M.I."). Recipients with N.A.M.I. are required by Medicaid to bear part of the cost of the medical services they receive. At issue here is whether the State should be responsible for collecting N.A.M.I. and bearing the loss for uncollected N.A.M.I. or whether the providers should bear those burdens.

New York has not always dealt with the N.A.M.I. question in the way that it does today. Between July 1, 1976 and July 2, 1978, the State and its providers, including Nightingale, treated N.A.M.I. collection in the following manner. The State imposed the initial collection burden on providers but, where a provider was unable to collect the funds due, the State permitted the provider to resubmit its bill and the State then reimbursed the provider for uncollected N.A.M.I. Thus, for that two-year period, the State acted as a guarantor.

On or about July 2, 1979, however, the State changed its procedures. It informed providers, including Night-

ingale, that they would no longer be reimbursed for uncollected N.A.M.I. Further, the State announced that this new policy would be retroactive to June, 1978 and that it would also apply to any unpaid bills for services rendered prior to that date. Since June, 1978 the State has continued to deduct an amount equal to recipients' N.A.M.I. from reimbursements paid to Nightingale. In those instances where Nightingale has been unable to collect its N.A.M.I., the State has refused and continues to refuse to reimburse it.

The State's motion on the N.A.M.I. issue, therefore, poses the following dispute. On the one hand, Nightingale claims that the Medicaid statute requires that providers be reimbursed for their services on a cost-related basis, that is, that the State pay providers for the reasonable expenses incurred to provide care. On the other hand, the State contends that the Medicaid statute either calls for reimbursement on the basis of recipients' means or is silent on this aspect of the program and leaves to the State the determination of who is to bear the burden of collecting N.A.M.I. Because I find that the statute allocates these burdens to participating states, the motion to dismiss plaintiff's N.A.M.I. claims for failure to state a claim is denied.

The Medicaid statute directs that:

> A state plan for medical assistance must . . . (13) provide— . . . (E) effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on *a reasonable cost basis,* as determined in accordance with methods and standards which shall be developed by the State on the basis of the cost-finding methods approved and verified by the Secretary . . . .

42 U.S.C. § 1396a(a)(13)(E) (emphasis added). In spite of this language, the State argues that § 1396a(a)(13)(E), without more, leaves open the reimbursement

question. While I would not dispute that the language of § 1396a(a)(13)(E) is summary in its allocation of the reimbursement burden to the State, it nevertheless clearly calls for a cost-based reimbursement program. Moreover, other sections of the Medicaid statute support this determination. For example, § 1396k provides participating states with certain powers to assist in their collection process.

In addition, numerous provisions in the regulations promulgated by the Department of Health and Human Services indicate that it is the Department's view that states, and not providers, are the guarantors of payment. Thus, 42 C.F.R. § 447.15 states that:

> A state plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amount paid by the agency.

Cf. 42 C.F.R. §§ 447.201(b), 447.301, 447.302(b), 447.331, and 447.273.

Moreover, while the precise question I decide today has not been ruled on by any other court, the Court of Appeals for the Tenth Circuit has reached a similar conclusion in an analogous case. *Seneca Nursing Home* v. *Secretary of Social and Rehabilitation Services of Kansas,* 604 F.2d 1309 (10th Cir. 1979). There, a dispute arose between a group of nursing homes and the State of Kansas over which of the two was ultimately liable to collect reimbursement payments chargeable to the private resources of welfare recipients. The Court resolved the question in favor of the nursing homes. It explained that:

> [the issue] is whether [the state agency] can refuse payment with respect to nursing home charges alleg-

> edly attributable to uncollected private liabilities payable from other patient resources. In essence [the state agency] argues that when it has established a formula as to how much the patient should be able to provide from his or her private resources, it agrees to pay only the difference between that sum and the total "reasonable, usual and customary" charges of the nursing home. It argues that the nursing home must demonstrate it has exhausted all efforts, apparently including legal action, in an attempt to obtain the payments the patients are to provide from their own resources before [the state agency] can be required to pay such charges. It is not clear [the state agency] agrees to pay the charges even if all collection efforts fail; but at least the argument appears to be that the state agency is no more than the guarantor of last resort. We are not persuaded.

Id. at 1314. While the Court of Appeals in the *Seneca* case was directing its opinion to another facet of the Medicaid reimbursement issue, I find that its reasoning is applicable to this question as well.

Finally, my holding today is consonant with federal policy. Congress created Medicaid to provide medical assistance and rehabilitative and other services to individuals who have demonstrated both medical and financial need. See 42 U.S.C. § 1396. Because the government does not directly provide medical services, Congress, in order to meet these needs, had to both allot funds in lieu of private payments for medical services and find and encourage individuals and institutions to provide the needed medical services. It is this second concern which the Medicaid statute addresses in 42 U.S.C. § 1396a(a)(13)(E) by ensur-

ing that providers will be reimbursed on the basis of their reasonable costs.[2]

Plaintiff's second set of claims arises out of the defendants' failure to timely pay bills which it submitted for medical services it performed. Nightingale alleges that it timely submitted a number of bills to the City and State agencies administering Medicaid which were either lost or delayed in processing. Nightingale claims, moreover, that the State has now refused to pay on those bills. As a partial defense to this claim, the State contends that it had delegated the repayment obligation from January 1, 1976 until on or about December 1, 1978 to the City.

Whatever the dealings were between State and City, it is clear that plaintiff has stated a federal claim. Section 1396a (a)(37) states that a state plan for medical assistance must

> provide for claims payment procedures which (a) ensure that 90 per centum of claims for payment . . . are paid within thirty days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt . . . .

Should the facts in this case demonstrate to me that the defendants are not in compliance with this section, relief will be appropriate. Moreover, I am not persuaded, as the State would have me be, that the State could repudiate its timely

---

[2] The legislative history addresses the need to encourage medical institutions to participate in the plan, as well. Speaking generally of the provisions of the plan that govern state payments to providers, the Senate Report states, "these provisions give reassurance that the hospital bill incurred by a needy individual *shall be paid in full* under the provisions of the State plan . . . and that States may not expect to require the individual to use his income or resources (except such income as exceeds the State's maintenance level) toward that bill." S.R. No. 404, 89th Cong. 1st Sess. 87 (1965), U.S. Code Cong. & Admin. News, p. 1943.

repayment obligations by merely shifting part of its administrative burden to the City. The statute requires participating states to lodge all administrative responsibility for Medicare in a "single State agency." *See* 42 U.S.C. § 1396a (a)(5). Whether or not a state chooses to delegate part of this responsibility to another governmental unit, the statute makes clear that responsibility ultimately remains with the single State agency.

This very question was presented to the Massachusetts federal district court, which held:

> it is clear that Title XIX mandates full and prompt payment by states to Medicaid providers for inpatient care. Thus, so long as [a state] participates in the Title XIX Medicaid program, federal law requires that [that state] promptly pay the full actual reasonable costs of inpatient care . . . . Any failure to do so, regardless of the reason, is a violation of the Social Security Act.

Massachusetts General Hospital v. *Sargent*, 397 F.Supp. 1056, 1062 (D.Mass. 1975). Finally, plaintiff has adequately pleaded its state contract law claim on its two-year-old bills arising out of the Provider Agreement over which I have pendent jurisdiction. I therefore find that plaintiff states a claim upon which relief can be granted.

Submit order on notice.

APPENDIX D

Judgment of the Court of Appeals

Florence Nightingale Nursing Home v. *Cesar Perales, individually and as Commissioner of the New York State Department of Social Services, and George Gross, individually and as Administrator/Commissioner of the New York City Human Resources Administration*

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

Docket Nos. 85-7755, 85-7759

At a stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York, on the twenty-fourth day of January, one thousand nine hundred and eighty-six.

Present:

HON. IRVING R. KAUFMAN,
HON. WILLIAM H. TIMBERS,
HON. JON O. NEWMAN,

Circuit Judges,

FLORENCE NIGHTINGALE NURSING HOME,

Plaintiff-Appellee,

--v—

CESAR PERALES, individually and as Commissioner of the New York State Department of Social Services, and GEORGE GROSS, individually and as administrator/Commissioner of the New York City Human Resources Administration,

Defendants-Appellants.

Appeal from the United States District Court for the Southern District of New York.

This cause came on to be heard on the transcript of record from the United States District Court for the Southern District of New York, and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now hereby ordered, adjudged and decreed that the Judgment of said District Court be and it hereby is reversed, the injunction is vacated, and the action be and it hereby is remanded to the said district court for further proceedings in accordance with the opinion of this court.

ELAINE B. GOLDSMITH,
Clerk

By: /s/ EDWARD J. GUARDARO
Edward J. Guardaro
Deputy Clerk

APPENDIX E

Federal Medicaid Act

42 U.S.C. § 1396a(a)(13)(A)

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * *

(13) provide—

(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1395x(v)(1)(G) of this title) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing

of uniform cost reports by each hospital, skilled nursing facility, and intermediate care facility and periodic audits by the State of such reports; . . .

APPENDIX F

S. Rep. No. 1230, 92d Cong., 2d Sess. 287-288 (1972)

Requirements for States Participating in Medicaid To Pay Skilled Nursing and Intermediate Care Facilities on a Reasonable Cost-Related Basis

(Sec. 249 of the bill)

Under the medicare program extended care facilities are reimbursed for the reasonable costs they incur in providing covered services plus, in the case of proprietary institutions, an allowance related to net capital equity. Under medicaid States have been free to develop their own bases for reimbursement to skilled nursing facilities and intermediate care facilities. States generally establish (in advance) per diem or similar basis rates payable for patients receiving skilled nursing facility and ICF care. Concern has been expressed that some skilled nursing facilities and ICF's are being overpaid by medicaid, while others are being paid too little to support the quality of care that medicaid patients are expected to need and receive.

On the other hand the reasonable cost reimbursement approach of the medicare program has in many cases created difficulties for extended care facilities. The detailed and expensive cost-finding requirements can prove cumbersome.

The committee bill would require States to reimburse skilled nursing and intermediate care facilities on a reasonable cost-related basis by July 1, 1974. This approach is preferable to the arbitrary rate-setting currently in effect in some States which provide no incentive to facilities to upgrade the level of care provided. The States would use acceptable cost-finding techniques (not necessarily those utilized for medicare purposes) to determine reasonable reimbursement and apply to the results appropriate methodologies for determining payment. The methods would have to be approved and validated by the Secretary. The com-

mittee does not intend that this provision should require use of the specific medicare reasonable cost reimbursement formula by States for purposes of reimbursing skilled nursing homes and intermediate care facilities under medicaid, although States are free to choose this option. Rather, the States could develop other reasonable cost-related methods of rate-setting. Whatever methodology is authorized should include adequate procedures for auditing, as necessary, the financial records of an institution. States would not be required to reimburse for luxury services, questionable allowances for depreciation and similar items which they might reasonably choose not to recognize as "reasonable." States would be free to provide for retroactive adjustments of rates or costs to the extent necessary to prevent "windfalls" or unjustifiably low payment. The Secretary would be expected to validate, on site, a State's methodology through ample audits. Reasonable cost-related rates could be determined on a geographic basis, a class basis, or on an institution-by-institution basis.

The committee amendment provides that cost reimbursement methods which the Secretary would find acceptable for a State medicaid program would also be adapted, with appropriate adjustments, in the State for purposes of medicare reimbursement. The Secretary would be permitted to adjust a rate upward where appropriate, to reimburse for specific factors related to medicare requirements (such as keeping a reasonable number of beds available, type of occupancy covered, any additional administrative costs) which are not considered by the State or included in the computation of its medicaid rates. Such adjustments would be distilled into a percentage factor (not in excess of ten percent) so as to simplify reimbursement. These percentage adjustments may be made on a geographic basis of classes of facilities and not necessarily on an institution-

by-institution basis. A similar provision was included in H.R. 17550.

Where a skilled nursing facility is a distinct part of, or directly operated by a hospital, reimbursement would be made for care in such facilities in the same manner as is applicable to the hospital's costs. Where a skilled nursing facility functions in a close formal medical satellite relationship with a hospital (which would be defined in regulations of the Secretary) reimbursement would be made on the basis of costs not to exceed 150 percent of the adjusted medicaid rate of payment (if the Secretary applies such rates to medicare facilities in that State) for care in that facility (or comparable facility).

This approach avoids substantial auditing and cost-finding expense, and provides a means of making equitable adjustments where appropriate.

(3)

Supreme Court, U.S.
FILED
JUL 11 1986
JOSEPH F. SPANIOL, JR.
CLERK

No. 85-1763

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM 1985

FLORENCE NIGHTINGALE NURSING HOME,

Petitioner,

vs.

CESAR PERALES, individually and as Commissioner of the New York State Department of Social Services, and GEORGE GROSS, individually and as Administrator/Commissioner of the New York City Human Resources Administration,

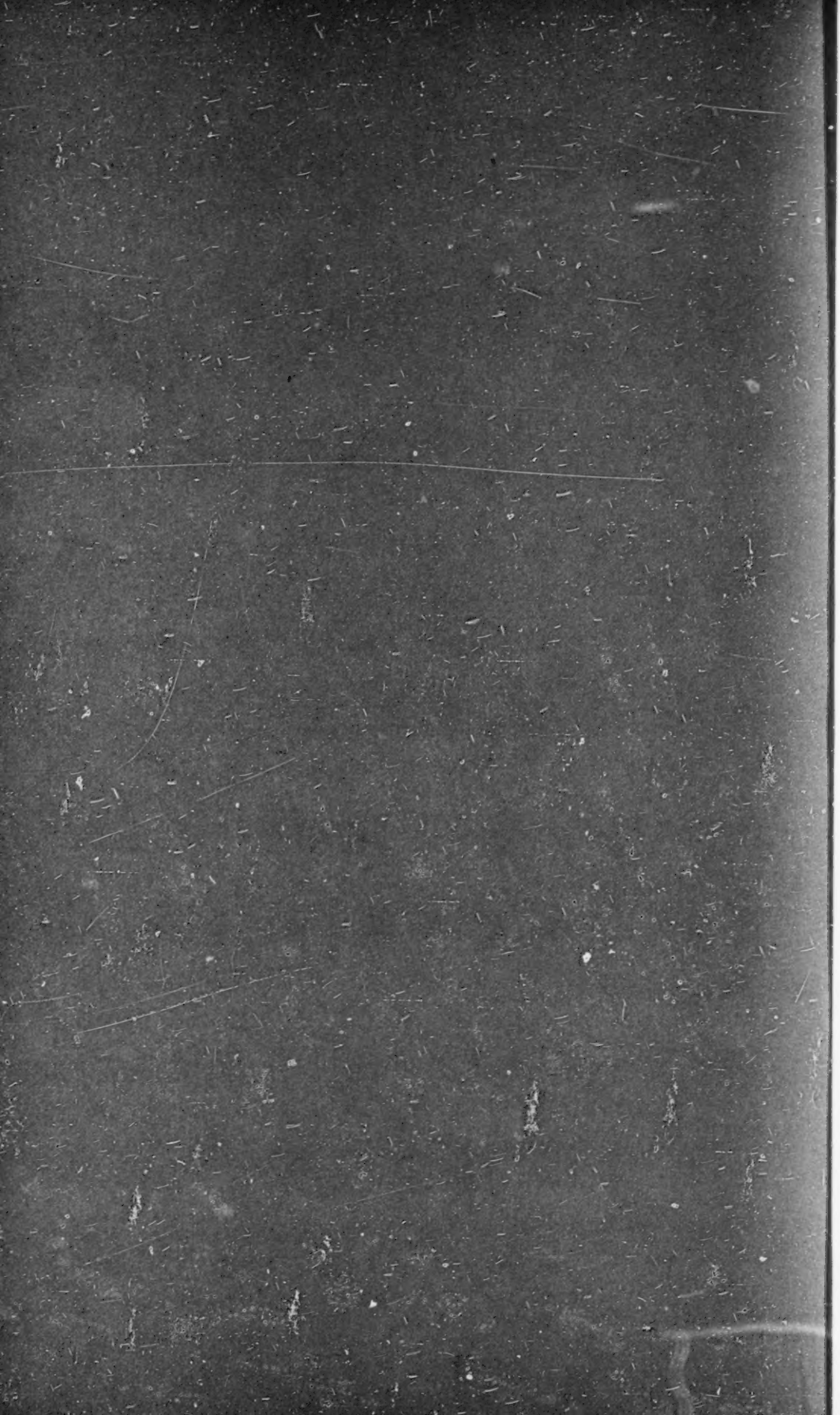
Respondents.

CITY RESPONDENT'S BRIEF IN OPPOSITION TO A PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

FREDERICK A. O. SCHWARZ, JR.,
Corporation Counsel of the
City of New York,
Attorney for City Respondent,
100 Church Street,
New York, N.Y. 10007.
(212) 566-1805 or 4328

LEONARD KOERNER,
STEPHEN J. McGRATH,
LORI FINSTERWALD,
of Counsel.

July 8, 1986.



QUESTION PRESENTED

Whether public funds can be used to reimburse petitioner nursing home for money owed by medicaid patients for the cost of care which is the patient's responsibility, where such reimbursement is prohibited by federal statute and regulations.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	iii
STATEMENT OF THE CASE	1
DECISIONS BELOW	8
REASONS FOR DENYING THE WRIT	
PETITIONER HAS FAILED TO SET FORTH SPECIAL OR IMPORTANT REASONS FOR GRANTING A WRIT OF CERTIORARI IN THIS MATTER	13
CONCLUSION	22

TABLE OF AUTHORITIES

Cases:	Page
Alabama Hospital Association v. Beasley, 702 F2d 955 (11th Cir., 1983)	20
Connecticut Department of Income Maintenance v. Heckler, ___ US ___, 105 S Ct 2210 (1985).....	14
DeJesus v. Perales, 770 F2d 316 (2d Cir., 1985)	14
Florence Nightingale Nursing Home v. Blum, 570 F Supp 285 (S.D.N.Y. 1983).....	5, 9
Florence Nightingale Nursing Home v. Perales, 782 F2d 26 (2d Cir., 1986)	11
Friedman v. Berger, 547 F2d 724 (2d Cir., 1976), cert. denied, 430 US 984 (1977).....	3
James v. Harris, 499 F Supp 594 (M.D. Ala. 1980), aff'd on opinion below, 650 F2d 814 (5th Cir., 1981)	16
Seneca Nursing Home v. Secretary of Social and Rehabilitation Services of Kansas, 604 F2d 1309 (10th Cir., 1979)	6, 9, 10, 11, 12, 13

Statutes:

42 USC §1396	2
42 USC §1396a(a)(13)(A).....	6
42 USC §1396a(a)(13)(E).....	6, 9, 15, 19, 20

Regulations:

42 CFR §405.420.....	18
42 CFR §435.725.....	16
42 CFR §435.733.....	16
42 CFR §435.832.....	16
42 CFR §435.1002.....	16
42 CFR §436.832	16
42 CFR §447.15.....	6, 9, 11, 12
42 CFR §477.53	18, 19

No. 85-1763

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM 1985

FLORENCE NIGHTINGALE NURSING HOME,

Petitioner,

vs.

CESAR PERALES, individually and as Commissioner of the New York State Department of Social Services, and GEORGE GROSS, individually and as Administrator/Commissioner of the New York City Human Resources Administration,

Respondents.

CITY RESPONDENT'S BRIEF IN OPPOSITION TO A PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

STATEMENT OF THE CASE

The medicaid program was enacted by Congress in 1965 under Title XIX of the Social Security Act to provide federal financial assistance to participating states for

the cost of providing health care to needy individuals (JA200, JA210).[1] See 42 USC §1396 et seq. Under the program a single state agency in each participating state is responsible for operating a statewide medical assistance plan (JA140, JA148). State respondent, Cesar Perales, is Commissioner of the New York State Department of Social Service ("DSS") which implements and administers the New York State medicaid program (JA148, JA201). City respondent, George Gross, is the Commissioner of the New York City Human Resources Administration ("HRA"), the local social service agency, which shares the cost of

---

[1]Unless otherwise indicated, references within parentheses preceded by "App." are to the Appendix to the Petition for Certiorari and those references preceded by "JA" are to the Joint Appendix filed in the Circuit Court.

long-term care with the federal and state governments and the patient (JA27).[2]

Medicaid patients who reside in long-term care institutions must contribute most of their income to help pay for the cost of their care, retaining only an allowance for their "personal needs" and such income as is deemed necessary to meet the maintenance needs of their former family household (JA201, JA202, JA210, JA211). See Friedman v. Berger, 547 F2d 724 (2d Cir., 1976), cert. denied, 430 US 984 (1977). The amount that the medicaid recipient is required to pay to the nursing home as his contribution

---

[2]Prior to December 1, 1978, DSS delegated to HRA the task of receiving and evaluating claims for reimbursement submitted by New York City providers, for services rendered to New York City residents (JA201, JA210). Since 1978, it is the State that receives, evaluates and pays such claims, and then seeks the local and federal contributory shares (JA201, JA210).

to the cost of care is known in New York State as the patient's Net Available Monthly Income ("NAMI") (JA202, JA211).

Petitioner, Florence Nightingale Nursing Home, furnishes long-term care to medicaid recipients (JA201, JA274, JA275). In October 1980, petitioner commenced this action in the United States District Court for the Southern District of New York, seeking, inter alia, reimbursement from State and City respondents for patients' uncollected contributions to the cost of care (JA9-11).[3]

---

[3]From 1973 to 1978, HRA reimbursed nursing homes, such as Florence Nightingale, for 98% of a recipient's NAMI, if the institution certified that it had been unable to collect the NAMI directly from the recipient (JA211). In a 1980 audit, the United States Department of Health and Human Services stated that, as a result of this policy, the City and State had overclaimed the sum of $1.1 million in federal medicaid funds (JA153, JA211, JA253). Subsequent thereto, the State recovered $1,751,162 from the City, alleging that, as a
(Footnote Continued)

On November 25, 1980, City respondent answered and State respondent moved to dismiss the complaint on the grounds, inter alia, that petitioner failed to state a claim (JA19, JA32).

In Florence Nightingale Nursing Home v. Blum, 570 F Supp 285 (S.D.N.Y. 1983), the District Court denied State respondent's motion to dismiss, holding that the state medicaid agency,not the nursing home, was required to bear the loss for the uncollected amount of a patient's contribution to the cost

---

(Footnote Continued)
result of the City's policy, the City had improperly appropriated this sum from the state and federal medicaid funds (JA211). HRA now believes that medicaid funds cannot be used to reimburse NAMI, even when the institution cannot collect the NAMI directly from the recipient (JA211, JA212). The City is, nonetheless, objecting in a state court proceeding to the State's action in recovering the $1,751,162, in large part because it alleges that DSS knew of and approved of the HRA's prior policy. City of New York v. State of New York, The New York Court of Claims, Claim No. 71082.

of care. (JA30, JA33). In reaching this conclusion, the District Court relied on a provision in the medicaid statute, 42 USC §1396a(a)(13)(E), which, at that time, required the state to pay for long-term care services provided under the plan on a "reasonable cost" basis[4] and a federal regulation, 42 CFR §447.15, which requires providers to accept, as payment in full, the amount paid by medicaid (JA30, JA33). In addition, the Court analogized to the decision in Seneca Nursing Home v. Secretary of Social and Rehabilitation Services of Kansas, 604 F2d 1309 (10th Cir.

---

[4]The statute was amended in 1980 to require state medicaid plans to provide payment at a rate which the state finds is "...reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 USC §1396a(a)(13)(A). This provision does not, however, require the state medicaid agency to reimburse the institution 100% of that rate.

1979) where the Court of Appeals held that under Kansas state law the state of Kansas should pay recipients' uncollected private liabilities (JA30, JA33).

On November 16, 1984, petitioner noticed a motion for partial summary judgment seeking declaratory and injunctive relief in addition to an award of $72,412.01 for payments allegedly owed by patients. Petitioner claimed that respondents were obligated to reimburse the nursing home for a patient's unpaid liability (JA101).

On December 17, 1984, City respondent cross-moved for partial summary judgment on the ground, inter alia, that pursuant to federal regulations, medicaid funds cannot be used to reimburse nursing homes for recipients' uncollected payments (JA199, JA208). Relying on the same federal regulations State respondent also

cross-moved for partial summary judgment (JA138).[5]

DECISIONS BELOW

The District Court issued an endorsed memorandum decision partially granting petitioner's motion for summary judgment and enjoining respondents from refusing to reimburse petitioner for Medicaid recipients' unpaid contributions (JA278). Petitioner's motion was denied to the extent that it sought an award of $72,412.01 for uncollected payments, and a trial was ordered on the issue of damages (JA278).

In granting petitioner's motion, the District Court recognized that its decision was contrary to federal regulations which require state medical assistance programs to

---

[5]In addition, State respondent sought leave to implead the United States Department of Health and Human Services ("HHS").

reduce their payments to long-term care institutions by a sum equal to the Medicaid patient's contribution to the cost of care (JA278). Rejecting these unambiguous federal regulations, the District Court however, based its decision on the reasoning set forth in the Court's prior opinion denying State respondent's motion to dismiss, Florence Nightingale Nursing Home v. Blum, 570 F Supp 285 (S.D.N.Y. 1983) (JA30, JA278). In denying the motion to dismiss the Court had relied on three factors: (1) a section of the medicaid statute, 42 USC 1396a(a)(13)(E), which, at that time, had provided for reimbursement based on a reasonable cost basis; (2) a federal regulation, 42 CFR §447.15, which required providers to accept as payment in full, the amount paid by the state medicaid agency; and (3) the Tenth Circuit decision in Seneca Nursing Home v.

Secretary of Social and Rehabilitation Services of Kansas (JA30).

City and State respondents appealed the District Court's order which was in clear conflict with federal regulations (JA292, JA298).[6] The United States Department of Health and Human Services ("HHS") submitted an amicus curiae brief in support of reversal.[7]

The United States Court of Appeals for the Second Circuit reversed the judgment of the District Court and vacated the injunction, holding that (App. A-6):

> Both the statute and the regulations make clear that the financial responsibility for patient

---

[6]State respondent also appealed from the District Court's denial of the State's motion for permission to implead HHS (JA298-299). On appeal, the Court of Appeals declined to reach the third-party issue (App. A-2).

[7]We are submitting with this brief in opposition one copy of HHS's brief to the Court of Appeals.

> NAMI is not borne by the Medicaid program. The burden of uncollectible NAMI does not fall on the city, state or federal government but rather on the institutional provider.

Florence Nightingale Nursing Home v. Perales, 782 F2d 26, 29 (2d Cir., 1986).

In reaching this conclusion, the Court of Appeals accorded substantial deference to HHS's view that 42 USC §1396a(a)(13)(E) required only reasonable cost based payments by the state for the cost of services covered by medicaid and that a patient's NAMI is not a covered service (App. A-4, App. A-5). The Court of Appeals noted that this interpretation of the statute was plainly supported by regulations prohibiting such reimbursement (App. A-5).

Rejecting the District Court's reasoning, the Court of Appeals concluded that neither 42 CFR §447.15 nor Seneca Nursing Home v. Secretary of Social and Rehabilitation Services of Kansas, supra, 604

F2d 1309, supported a determination that the providers were entitled to reimbursement for unpaid NAMI (App. A-5, App. A-6). The Court of Appeals noted that 42 CFR §447.15 simply prevents providers from seeking contributions from patients in excess of the limits set by medicaid, and does not transfer responsibility for payment of the patient's liability to the Medicaid agency (App. A-5). Moreover, the Court of Appeals concluded that the decision in Seneca Nursing Home was inapplicable. In Seneca Nursing Home the Court of Appeals for the Tenth Circuit held that the state medicaid agency was required under a Kansas statute to reimburse the medical provider for patients' uncollected contributions (App. A-5). The Second Circuit stressed that in this case there is no such provision in the federal statute nor is there a New York statute analagous to the Kansas statute (App. A-6).

REASONS FOR DENYING THE WRIT

PETITIONER HAS FAILED TO SET FORTH SPECIAL OR IMPORTANT REASONS FOR GRANTING A WRIT OF CERTIORARI IN THIS MATTER.

Petitioner seeks this Court's review on the grounds, inter alia, that the Court of Appeals' ruling that the city, state and federal government are not required to reimburse petitioner for uncollectible NAMI is in conflict with the decision of the Court of Appeals for the Tenth Circuit in Seneca Nursing Home v. Secretary of Social and Rehabilitation Services, supra. However, as petitioner acknowledges the Seneca decision allowing reimbursement to a nursing home for patients' contributions to the cost of care was based on a Kansas statute, and not federal or New York law. Therefore, no actual conflict between the circuits has been presented to this Court. Nor has petitioner

presented any other reason warranting this Court's review.

The Court of Appeals properly accorded substantial deference to HHS's view that uncollected NAMI is not reimbursable (App. A-5). See Connecticut Department of Income Maintenance v. Heckler, ___ US ___, 105 S Ct 2210, 2215 (1985); DeJesus v. Perales, 770 F2d 316, 327 (2d Cir., 1985). This view was set forth in an amicus curiae brief submitted by HHS to the United States Court of Appeals in support of reversal of the District Court's order (App. A-5). Petitioner has failed to set forth any reasons why this Court should review the judgment of expert administrators on an issue which raises complex questions of federal statutory interpretation.

In its amicus curiae brief HHS explained that pursuant to detailed reimbursement procedures, the states reimburse the

provider or nursing home under prescribed reimbursement rates for medicaid care costs, for services provided under the plan. These medicaid care costs, according to HHS, do not include that portion of a patient's care for which the patient is financially responsible (App. A-4). As interpreted by HHS, section 1396a(a)(13)(E) does not provide for 100% reimbursement of the reasonable cost of services where such services are not covered by Medicaid or "provided under the plan" because of a patient's available income (App. A-4).[8]

The Court of Appeals correctly found that HHS's interpretation of the statute was further supported by federal regulations drafted by HHS which prohibit

---

[8]Paragraph E as enacted provided for reimbursement for services rendered under the plan on a reasonable cost related basis.

reimbursement to nursing homes of a patient's contribution to the cost of care (App. A-5).[9] 42 CFR §§435.725; 435.733; 435.832; 435.1002; 436.832. The regulations unambiguously provide that:

> The agency must reduce its payments to an institution for services provided to an individual..., by the amount that remains after deducting the amounts specified in paragraph (c) of this section [referring to an individual's personal needs allowance] from the individual's income.

42 CFR §§432.725 and 435.832 (emphasis added). See also James v. Harris, 499 F Supp 594 (M.D. Ala. 1980), aff'd on opinion below, 650 F2d 814 (5th Cir., 1981). As HHS stated in its brief these federal regulations make clear that states may not pay institutions the patient's NAMI.

---

[9] 42 CFR §§435.725 and 435.1002 were promulgated in 1978, two years prior to the commencement of this action.

Petitioner claims without any citation of supporting legislation or legislative history that these regulations, which were promulgated by the agency with expertise in the field, are in conflict with the language and purpose of the medicaid statute. In contrast, the New York State Health Facilities Association, Inc. ("NYSHFA"), the Connecticut Association of Health Care Facilities Inc. ("CAHCF") and the American Health Care Association ("AHCA"), which have submitted an amici curiae brief in support of the petition for a writ of certiorari, note these regulations in a footnote and claim that they are "self-serving". The amici argue that the Court of Appeals' conclusion is incorrect because the Court allegedly confused the concepts of reimbursement, eligibility and costs in deciding this case. There is no merit to any of these contentions. The Court

of Appeals never even considered eligibility standards and it is the amici curiae who attempt to intertwine these distinct concepts.

In addition, petitioner now argues for the first time that a patient's contribution to the cost of care is reimbursable under medicare and that therefore such reimbursement should be permitted under medicaid. 42 CFR §405.420, the medicare regulation cited by petitioner for this proposition, limits reimbursement to bad debts attributable to deductibles and coinsurance amounts for covered services. It does not provide that NAMI is reimbursable under medicare.

NAMI is not a deductible or coinsurance amount. A medicaid regulation, 42 CFR 447.53, specifically excludes NAMI payments from the category of cost sharing under medicaid which includes deductibles and coinsurance. Under this regulation, the

medicaid plan may impose a nominal deductible, coinsurance, copayment or similar cost-sharing charge on the medicaid recipient. However excluded from such cost-sharing charges are institutionalized patients who are required to pay NAMI. 42 CFR 447.53 provides:

> Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution if the individual is required (pursuant to §§435.733, 435.832, or 436.832), as a condition of receiving services in the institution, to spend all, but a minimal amount of his income required for personal needs, for medical care costs are excluded from cost sharing.

Moreover, even if a patient's NAMI were reimbursable under the medicare statute and regulations, those provisions are not controlling. Section 1396a(a)(13)(E), originally gave states an opportunity, but did not require them, to reimburse medicaid providers in the same manner as medicare providers. Moreover, in 1980, section

1396a(a)(13)(E) was amended by §962 of the Omnibus Reconciliation Act to require states to provide payment through reasonable and adequate rates. "In revising the statute Congress sought to move away from the inflationary medicare reimbursment methodology.... Congress intended the efficient cost standard to reduce, not increase, the permissible level of reimbursement below that available under Medicare principles." Alabama Hospital Association v. Beasley, 702 F2d 955, 959, 960 (11th Cir., 1983).

Finally, there is no factual support in the record for petitioner's claim that nursing homes will incur severe monetary losses and withdraw from the medicaid program as a result of the Court of Appeals' decision in this case. Indeed, the record contradicts such an assertion. Uncollected NAMI has not been reimbursed in New York since 1978 and

there is nothing in the record to show that severe losses leading to withdrawals have occurred during the past eight years. See discussion, supra, at 4-5, n. 3.

Petitioner claims that it has not been reimbursed for uncollected NAMI since 1976 (JA 108). While petitioner contends that "...the amount at stake in this controversy is substantial", it does not assert that the $72,412 it claims in damages has forced it to withdraw from the program. Vague, speculative arguments about the effects of the Court of Appeals decision do not provide any special or important reason for granting a writ of certiorari. The petition should be denied.

CONCLUSION

THE PETITION FOR A WRIT OF CERTIORARI SHOULD BE DENIED.

July 8, 1986.

Respectfully submitted,

FREDERICK A. O. SCHWARZ, JR.,
Corporation Counsel of the City
of New York,
Attorney for City Respondent.

LEONARD KOERNER,
STEPHEN J. McGRATH,
LORI FINSTERWALD,
of Counsel.

No. 85-1763

Supreme Court, U.S.
FILED
JUL 25 1986
JOSEPH F. SPANIOL, JR.
CLERK

IN THE

Supreme Court of the United States

October Term, 1985

FLORENCE NIGHTINGALE NURSING HOME,

Petitioner,

against

CESAR PERALES, individually and as Commissioner of the New York State Department of Social Services, and GEORGE GROSS, individually and as Administrator/ Commissioner of the New York City Human Resources Administration,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

MEMORANDUM IN OPPOSITION FOR RESPONDENT PERALES

ROBERT ABRAMS
Attorney General of the
State of New York
Attorney for Respondent Perales
Two World Trade Center
New York, New York 10047
(212) 488-4842

O. PETER SHERWOOD
Solicitor General

JUDITH A. GORDON
Assistant Attorney General and Counsel of Record
of Counsel

EDITOR'S NOTE

THE FOLLOWING PAGES WERE POOR HARD COPY AT THE TIME OF FILMING. IF AND WHEN A BETTER COPY CAN BE OBTAINED, A NEW FICHE WILL BE ISSUED.

TABLE OF AUTHORITIES

PAGE

Cases:

Connecticut Department of Income Maintenance v. Heckler, 105 S. Ct. 2210 (1985) 9

DeJesus v. Perales, 770 F.2d 316 (2d Cir. 1985) 9

Florence Nightingale Nursing Home v. Perales, 782 F.2d 26 (2d Cir. 1986) 2

Friedman v. Berger, 547 F.2d 724 (2d Cir. 1976), *cert. denied*, 430 U.S. 984 (1977) 3

James v. Harris, 499 F. Supp. 594 (M.D. Ala. 1980), *aff'd on opinion below*, 650 F.2d 814 (5th Cir. 1981) 4, 10

Lorillard v. Pons, 434 U.S. 575 (1978) 9

Seneca Nursing Home v. Secretary of Social and Rehabilitation Services 604 F.2d 1309 (10th Cir. 1979) 11, 12

Sigety v. Ingraham, 29 N.Y. 2d 110 (1971) 6, 8

Federal Statues, Regulations and Rules:

42 U.S.C. § 1396(a) 6
§ 1396a(a)(13)(A) 4, 5, 6, 7, 8, 9
§ 1396a(a)(13)(E) 2, 4, 5, 6, 9
§ 1396a(a)(17) 2, 6, 7, 9
Pub. L. 92-603, § 249 (1972) 4
Pub. L. 96-499, § 862 (1980) 4

	PAGE
42 CFR § 405.420	10, 11
§ 435.3	7
§ 435.725	*passim*
§ 435.726	2, 3
§ 435.733	2, 3
§ 435.735	2, 3
§ 435.832	*passim*
§ 435.1002	3, 4, 11
§ 436.832	2, 3
§ 447.53	11
Supreme Court Rule 17	3
21	4

New York Constitution, Statutes and Regulation:

Const. art. 17 § 1	12
§ 3	12
Social Services Law § 365-a	2
18 NYCRR § 360.5	2, 3, 4, 7, 11

Miscellaneous:

43 FR 45204 (Sept. 29 1978)	9

No. 85-1763

IN THE

Supreme Court of the United States

October Term, 1985

FLORENCE NIGHTINGALE NURSING HOME,

Petitioner,

against

CESAR PERALES, individually and as Commissioner of the New York State Department of Social Services, and GEORGE GROSS, individually and as Administrator/Commissioner of the New York City Human Resources Administration,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

MEMORANDUM IN OPPOSITION FOR RESPONDENT PERALES

Petitioner is a skilled nursing home in New York City that serves private and Medicaid long-term care patients. It seeks plenary consideration of an opinion and judgment of the United States Court of Appeals for the Second Circuit which holds, correctly, that the nursing home, not

government, bears the loss when the home is unable to collect money Medicaid patients owe it from their own funds. *Florence Nightingale Nursing Home* v. *Perales*, 782 F.2d 26 (2d Cir. 1986) (App. A-1[1]).

The Second Circuit opinion recognizes that to the extent a Medicaid patient is required to pay for his care from his own funds, i.e. from "patient income" under federal regulations[2] or "net available [monthly] income" ("NAMI") under state regulation,[3] he is paying for services for which he is not Medicaid-eligible and for which his provider cannot be Medicaid-reimbursed. App. A-4 (citing, *inter alia*, former 42 U.S.C. § 1396a[a][13][E], in force when petitioner's damage claims accrued). *Accord* 42 U.S.C. § 1396a (a)(17) (state plan standards must determine both patient "eligibility for and the extent of medical assistance"); New York Social Services Law § 365-a ("medical assistance" defined as "payment of part or all of the cost of care").

The opinion finds, in consequence, that the federal regulations, 42 CFR §§ 435.725 (categorical Medicaid eligibility) and 435.832 (Medicaid-only eligibility), which specifically prohibit institutional providers from receiving reimbursement for money payable from long-term care patient income, or NAMI, implement federal statutory require-

1. References preceded by "App." are to pages of the appendices to the petition.

2. 42 CFR §§ 435.725, 435.726, 435.733, 435.735, 435.832, 436.832.

3. 18 New York Codes, Rules and Regulations ("NYCRR") § 360.5.

ments. App. A-4-A-5.[4] *Accord* 42 CFR § 435.1002(b) (federal financial participation not available, *inter alia,* for costs payable by long-term care Medicaid patients); 18 New York Codes, Rules and Regulations ("NYCRR") § 360.5 (e) (conforming state regulation); *Friedman* v. *Berger,* 547 F.2d 724 (2d Cir. 1976), *cert. denied,* 430 U.S. 984 (1977) (§ 360.5 [e] setoff on Medicaid reimbursement, up to $28.50, now $40, monthly personal needs allowance, held consistent with federal program requirements).[5]

Petitioner offers three arguments against the Second Circuit opinion and judgment upholding 42 CFR §§ 435.725, 435.832 and the conforming state policy under 18 NYCRR § 360.5(e).[6] None of the arguments presents a special or important reason within Supreme Court Rule 17(1) for

---

4. Sections 435.725 and 435.832 both state at paragraph (a): "The [state] agency must reduce its payment to an institution, for services provided to an individual [Medicaid patient] . . ., by the amount that remains after deducting the amounts specified in paragraph (c) . . . from the individual's income." Paragraph (c) allows deductions for the personal needs of long-term care patients, for spousal support and for family support. *Id.* at (1)-(3). Only the personal needs deduction applies to all long-term care patients.

5. The amount of income, or NAMI, a Medicaid patient must pay for his care varies with his available income and resources and with his care status. But, long-term care patients always pay more than outpatients with equivalent income and resources. The reason is self-evident. Providers charge long-term care patients for maintenance needs, e.g. shelter, food, whereas they do not charge outpatients for these needs. Thus, lon-term care patients do not receive a deduction for maintenance needs whereas outpatients do. *Compare* 42 CFR §§ 435.725(c), 435. 733(c), 435.832(c), 436.832(c), 18 NYCRR 360.5(e) (no deduction for individual maintenance needs for long-term care patients) *with* 42 CFR §§ 435.726(c)(1), 435.735 (c)(1), 18 NYCRR § 360.5(b),(c) (deduction for individual maintenance needs for outpatients).

6. Petitioner adopts an unusual argumentative approach. It claims inconsistency between the state policy requiring NAMI setoffs

(footnote continued on next page)

granting a writ of certiorari. And, all three involve manifest error.

Petitioner argues first, and principally, that 42 CFR §§ 435.725, 435.832 and the conforming state policy offend the terms of the "governing" Medicaid statute. Petition at 7, 11. It identifies one state plan subsection, 42 U.S.C. 1396a(a)(13)(E), Pub. L. 92-603, § 249 (1972), amended and renumbered § 1396a(a)(13)(A), Pub. L. 96-499, § 862

(footnote continued from preceding page)

on Medicaid reimbursement and the terms or intent of the federal Medicaid statutes without addressing the controlling federal regulations, 42 CFR §§ 435.725, 435.832. See Petition at 12, 14 (identifying §§ 435.725, 435.832 only indirectly, perhaps with other regulations as the "regulations" adopted by the United States Department of Health and Human Services). See also Brief in Support of the Petition for *Amici Curiae* New York State Health Facilities Association, Inc., Connecticut Association of Health Care Facilities, Inc. and American Health Care Association ("amici curiae brief") (mentioning only the "regulations" in the text [at 10, 11], but identifying §§ 435.725, 435.832, in footnotes [at 3, 11]).

We follow a more traditional approach and consider the state policy, i.e. 18 NYCRR § 360.5(3), in relation to the federal Medicaid statutes and in relation to the specific federal regulations that "command" the state policy. *James* v. *Harris*, 499 F. Supp. 594, 598 (M.D. Ala. 1980), *aff'd on opinion below*, 650 F.2d 814 (5th Cir. 1981) (citing 42 CFR § 435.725, identical to § 435.832 in all material respects; see p. 3 n.4).

Our approach informs the Court that the question presented subsumes challenges to 42 CFR §§ 435.725, 435.832 although the petition does not set out the regulations. See Supreme Court Rule 21 (1)(f). Contrast petition at 2 (regulations omitted). It also informs the Court that if certiorari were granted, the Court would have to remand the cause to join the Secretary of the United States Department of Health and Human Services before it could enter an appropriate order in petitioner's favor. See App. A-2 (state respondent's claim that the Secretary was a necessary party not reached because of finding in his favor). For example, if petitioner prevailed without the remand, the state would have to eliminate NAMI setoffs on Medicaid reimbursement but would not receive commensurate federal financial participation ("FFP") because the federal regulations which command the setoffs, i.e. 42 CFR §§ 435.725 and 435.832, would remain intact. See also 42 CFR § 435.1002(b) (FFP not available for costs payable from patient income, or NAMI).

(a) (1980).[7] It then claims, incorrectly, that the phrase in the 1980 text of § 1396a(a)(13)(A), "payment . . . of . . . services provided under the plan through . . . rates . . . reasonable and adequate to meet the costs which must be incurred . . . to provide care and services in conformity with applicable . . . Federal laws, [and] regulations," means that nursing homes must be "fully reimbursed" for all the costs of all the services they provide to Medicaid patients, including the costs of the services payable from patient income, or NAMI. Petition at 10-11.

Petitioner's reading of § 1396a(a)(13(A) involves several errors. One, § 1396a(a)(13)(A) does not reimburse all

---

7. The 1980 text of 42 U.S.C. § 1396(a)(13)(A) states in part: "A State plan for medical assistance must—(13) provide—(A) for payment . . . of . . . skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards . . . ."

The 1972 text of § 1396a(a)(13)(E) stated in part: "A state plan for medical assistance must—(13) provide—(E) . . . for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost finding methods approved and verified by the Secretary . . . ."

The city and state respondents claimed below that the substitution of the 1972 phase, "payment . . . on a reasonable cost basis . . ., as determined in accordance with methods and standards . . . developed by the State . . . on the basis of cost finding methods approved . . . by the Secretary," by the 1980 phrase, "payment . . . through the use of rates (determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs . . . incurred by efficiently and economically operated facilities," did not materially amend the subsection. The petitioner now agrees. Petition at 10.

nursing home services provided to Medicaid patients. By its terms, the subsection only reimburses "services provided under the [state] plan" which, in turn, is defined by other federal laws, including the other forty-five subsections in § 1396a(a). Nor does § 1396a(a)(13(A) pay all the costs of the covered state plan services it reimburses. By its terms, the subsection only pays "reasonable," "adequate" cost-based "rates."[8]

Two, petitioner ignores § 1396a(a)(17), the state plan subsection that places services payable from patient income, or NAMI, outside the state plan, thereby eliminating them from reimbursement under § 1396a(a)(13)(A). Subsection 1396a(a)(17) empowers the Secretary of the United States Department of Health and Human Services to prescribe income and resource limits on patient "eligibility for [Medicaid] and the extent of . . . [Medicaid] assistance." Under the subsection's authority, the Secretary has prescribed these limits for long-term care patients in 42 CFR §§ 435.725, 435.832, denying them "eligibility" and "assistance" to the extent of their income, or NAMI. See 42

8. New York has used cost-based rates to reimburse state plan services at least since 1968. *Sigety* v. *Ingraham*, 29 N.Y.2d 110, 112-13 (1971). The period includes the time between 1972 and 1980 when former § 1396a(a)(13)(E) was in force. Thus, to the extent petitioner suggests that the respondents' claim that § 1396a(a)(13)(A) did not materially amend § 1396a(a)(13)(E) means that all the costs of state plan services were reimbursed under § 1396a(a)(13)(E) and are now reimbursable under § 1396a(a)(13)(A), it is incorrect under the terms of § 1396a(a)(13)(E) ("methods and standards" "approved by the Secretary" necessary to determine the "reasonable cost basis" for reimbursement) and their application by the responsible single state agency in New York. See p. 5 n.7; petition at 10.

CFR § 435.3 citing § 1396a[a][17] as statutory authority for §§ 435.725, 435.832).[9]

Thus, when a nursing home provides a Medicaid patient with services payable from patient income, or NAMI, it provides services for which the patient is not Medicaid-eligible and for which Medicaid reimbursement, or "assistance," cannot be paid. Contrast petition at 11 (claiming " 'services provided under the [state] plan' " include services for which a Medicaid patient is not eligible); amici curiae brief at 10-11 (claiming Medicaid eligibility and Medicaid reimbursement are independent and unrelated). Or, as the Second Circuit opinion said, in summary: "NAMI represents the amount that a patient is required to contribute to his or her care. This contribution [for non-Medicaid costs] reduces the amount that the patient is eligible to have paid on his or her behalf . . . ." App. A-4. Contrast petition at 11 (claiming that the Second Circuit found that the costs of services payable from patient income, or NAMI, were not " 'costs' " when the court, in fact, found [at App. A-4] that they were not "costs . . . covered by Medicaid."[10]

9. The amici curiae brief (at 3 n.*, 10-11) accepts 42 CFR §§ 435.725, 435.832 and the conforming state regulation, 18 NYCRR § 360.5(e), as authorized by § 1396a(a)(17). As noted (p. 3 n.6), the petition does not address §§ 435.725, 435.832 and § 360.5(e) directly. However, it appears to concede that they are authorized when it acknowledges that Medicaid patients are "obliged by law" to pay a portion of the costs of state plan services. Petition at 11.

10. The amici curiae brief (at 8-9) claims that the Second Circuit analysis, tracked here, incorporates "fundamental error" (*id.* at 8) because it confuses rates and costs. The error lies with the amici curiae who completely misapprehend the relationship between rates, setoffs for patient income, or NAMI, and reimbursement for state plan services in New York.

New York initially includes the costs of services payable from patient income, or NAMI, in calculating the cost-based rates § 1396a

(footnote continued on next page)

Three, if the Court considers petitioner's contention that unless § 1396(a)(13)(A) is read to reimburse all costs of all services nursing homes provide to Medicaid patients, the homes will be obliged to decline Medicaid admissions and reduce quality of care (petition at 7, 8-9; see amici curiae brief at 5, 6-7, 11-12), the New York Court of Appeals provided the appropriate response fifteen years ago in *Sigety* v. *Ingraham*, 29 N.Y.2d 110 (1971). In rejecting the argument advanced by petitioner, there the plaintiff-respondent, that it was entitled to reimbursement in excess of the current rate because its costs exceeded the rate, the court said that projected adverse effects did not provide a basis for declaring the rate and underlying state regulation invalid. *Id.* at 114, 115-16. The court also said that if petitioner, a proprietary nursing home, could not realize a profit at the current reimbursement rate, it could either deliver its services more efficiently or leave the Medicaid program. *Id.* at 115. Petitioner has not yet elected the second option.

Petitioner next argues that Congress did not intend nursing homes to bear the costs of services payable from patient income, or NAMI, if the patient's payment is uncollectible and, for that reason, becomes a nursing home bad debt. Petition at 7, 10, 11-14; see amici curiae brief at 5, 10, 12, 13. Petitioner relies, alternatively, on Congressional intent allegedly expressed in the Medicaid

---

(footnote continued from preceding page)

(a)(13)(A) requires. Contrast amici curiae brief at 9 (stating that NAMI costs are never treated as " 'costs' " and never enter into the rate calculation process). The state then aggregates the patient income, or NAMI, payable by Medicaid patients in a given nursing home, sets it off against the home's rate, and pays the balance. The state, thereby, reimburses the home under § 1396a(a)(13)(A) only for services provided under the state plan. See pp. 5-8. Contrast amici curiae brief at 9 (stating that it is wrong to deduct NAMI from the nursing home rates).

statutes (Petition at 7, 10, 11-12, 14) and in the Medicare statutes. *Id.* at 13-14.

The Second Circuit opinion observes that uncollectible patient income, or NAMI, could, arguably, be reimbursed as an overhead cost under the Medicaid statutes, but it concludes that the Secretary's view, expressed in 42 CFR §§ 435.725, 435.832, prohibiting reimbursement, is more reasonable and entitled to particular deference. App. A-5. *Accord Connecticut Department of Income Maintenance* v. *Heckler*, 105 S. Ct. 2210, 2215 (1985); *DeJesus* v. *Perales*, 770 F.2d 316, 327 (2d Cir. 1985).

The opinion's conclusion is incontestable for several reasons. One, Congress made its intent manifest in 42 U.S.C. §§ 1396a(a)(13)(A), 1396a(a)(17), and it denied Medicaid reimbursement of uncollectible patient income, or NAMI. See pp. 5-8.

Two, given the promulgation of 42 CFR §§ 435.725, 435.832 in their current form in 1978 (43 FR 45204 [Sept. 29, 1978]), Congress knew the Secretary's view when it amended § 1396a(a)(13)(E) in 1980 and did nothing to modify or overide it. *Lorillard v. Pons*, 434 U.S. 574, 580-81 (1978). Contrast petition at 14 & n.5 (claiming that the Secretary did not prohibit Medicaid reimbursement of uncollectible patient income, or NAMI, until 1982 but acknowledging pre-existing regulations).

Three, the prohibitions against Medicaid reimbursement of uncollectible patient income, or NAMI, in 42 CFR §§ 435.725, 435.832 recognize, correctly, that a Medicaid patient owes his share of the costs of his care, i.e. the costs of

services for which he is not Medicaid-eligible, to his nursing home provider, not to governmental third-party payors. And, they recognize, again correctly, that transactions between Medicaid patient debtors and provider creditors with respect to these costs are matters in which the government has no legal interest.

In contrast to petitioner's claim (petition at 7, 10, 12; see amici curiae brief at 5, 10, 12, 13), the patient debtor-provider creditor relationship does not expand to include the government, much less impose on it the role of guarantor, if the patient or the provider defaults in his obligations. *See James* v. *Harris*, 499 F. Supp. 594, 598 (M.D. Ala. 1980), *aff'd on opinion below*, 650 F.2d 814 (5th Cir. 1981) (recognizing a Medicaid patient's obligation to pay his share of the costs of his care and acknowledging that 42 CFR § 435.725, like § 435.832, "commands" commensurate setoffs from Medicaid reimbursement).

Petitioner, relying alternatively on the Medicare statutes, claims that Congress intends Medicare to reimburse bad debts, akin to uncollectible patient income, or NAMI, and to permit reimbursement of the same bad debts under Medicaid. Petition at 11-13. The argument fails for three reasons.

One, 42 CFR § 405.420, the regulation petitioner cites as specific authority for Medicare's reimbursement of bad debts like uncollectible patient income, or NAMI, only authorizes reimbursement for bad debts related to "covered services." *Id.* at (a)(1). Under Medicaid, patient income, or NAMI, relates to 'uncovered,' i.e. non-state plan, services

See pp. 5-8.

Two, § 405.420(a)(1) only authorizes Medicare reimbursement for bad debts derived from "deductible and coinsurance amounts." Medicaid excludes patient income, or NAMI, from deductible and co-insurance amounts. 42 CFR § 447.53

Three, even if petitioner's comparison between Medicaid and Medicare was not flawed, it shows only that Congress intended states to have the option of reimbursing bad debts that result from uncollectible patient income, or NAMI. New York has declined the option, as evidenced by 18 NYCRR § 360.5(e), and, as petitioner concedes, it had the right to do so.

Last, petitioner argues that the Second Circuit opinion conflicts, in principle, with the Tenth Circuit opinion in *Seneca Nursing Home* v. *Secretary of Social and Rehabilitation Services*, 604 F.2d 1309 (10th Cir. 1979). Petition at 15; see amici curiae at 12-13. There is no conflict.

As both the Second Circuit and petitioner observe, *Seneca* holds (604 F.2d at 1314-15) that a Kansas statute obligates the state to reimburse nursing home providers when they are unable to collect a Medicaid patient's share of the costs of his care from the patient. App. A-5-A-6; petition at 15. The holding does not consider Kansas' obligations under the federal Medicaid program. It, therefore, does not address the prohibitions against Medicaid reimbursement of patient income, or NAMI, in 42 CFR §§ 435.725, 435.832 that are controlling here or the consequent denial of federal financial participation, under 42 CFR § 435.1002(b), to states that violate the prohibitions.

As the Second Circuit also observes, New York does not have a statute analogous to the Kansas statute. App. A-6. Thus, Kansas can reimburse uncollectible patient income, or NAMI, from its general assistance funds while New York cannot. New York Const. art. 17, §1 (aid, care and support of the needy shall be provided by the state as the legislature determines); *id.* at § 3 (legislature shall determine the manner and means of promoting and protecting the health of the state's inhabitants). And, in consequence, the result the Tenth Circuit reached in *Seneca* is not inconsistent with the result the Second Circuit reached in this case.

Therefore, the petition for a writ of certiorari should be denied.

Dated: New York, New York
July 25, 1986

Respectfully Submitted,

ROBERT ABRAMS
Attorney General of the
State of New York
Attorney for Respondent
Perales
Two World Trade Center
New York, New York 10047
(212) 488-4842

O. PETER SHERWOOD
Solicitor General

JUDITH A. GORDON
Assistant Attorney General and Counsel
of Record
of Counsel

Supreme Court, U.S.
FILED
JUL 7 1986
JOSEPH F. SPANIOL, JR.
CLERK

(2)

No. 85-1763

IN THE

Supreme Court of the United States

October Term, 1985

FLORENCE NIGHTINGALE NURSING HOME,
Petitioner,

against

CESAR PERALES, Individually and as Commissioner of the New York State Department of Social Services, and GEORGE GROSS, Individually and as Administrator/Commissioner of the New York City Human Resources Administration,

Respondents.

Brief of the New York State Health Facilities Association, Inc.; Connecticut Association of Health Care Facilities, Inc.; and American Health Care Association, *Amici Curiae,* In Support of Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

CORNELIUS D. MURRAY, ESQ.
100 State Street
Albany, NY 12207
Tel.: (518) 462-5601
Attorney for Amici Curiae

SARAH W. BIRN, ESQ.
O'Connell and Aronowitz
Of Counsel

June 24, 1986

19pp

Table of Contents.

	Page
Table of Authorities	ii
Statement of Interest	1
Summary of Argument	5
Argument	6
I. This Case Could Have Profound National Implications For The Medicaid Program	6
II. The Decision Of The Circuit Court Was Erroneous	8
III. The Second Circuit's Decision Conflicts With A Decision By The Tenth Circuit	12
Conclusion	13

TABLE OF AUTHORITIES.

CASES:

Children's Memorial Hospital v. Illinois Department of Public Aid, 562 F. Supp. 165 (D.C., M.D. Ill. 1983)	11
DeGregorio v. O'Bannon, 500 F. Supp. 541, (D.C., E.D. Pa. 1980)	7, 10
Espinoza v. Farah Manufacturing Company, 414 U.S. 86 (1973)	11

Page

Florence Nightingale v. Blum, 570 F. Supp. 285 (D.C., S.D.N.Y. 1983) 10

James v. Harris, 499 F. Supp. 594 (D.C., M.D. Ala. 1980) 10

O'Bannon v. Town Court Nursing Center, 447 U.S. 773 (1980) 7

Red Lion Broadcasting Co. v. FCC, 395 U.S. 367 (1969) 11

Roberson v. Wood, 500 F. Supp. 854 (D.C., S.D. Ill. 1980) 7

Seneca Nursing Home v. Secretary of Social and Rehabilitation Services, 604 F.2d 1309 (10th Cir. 1979) 6, 10, 12

STATUTES:

42 U.S.C. §1396 ..... 2, 13

42 U.S.C. §1396a(a)(5) 6, 11, 13

42 U.S.C. §1396a(a)(13)(A) 5, 9, 10, 11

42 U.S.C. §1396a(a)(13)(E) former provision 5

42 U.S.C. §1396a(a)(17) 5

42 U.S.C. §1396b 11

N. Y. Pub. Health Law §2801-a.3 (McKinney 1985). 4

Page

N. Y. Soc. Services Law §364.1(e) (McKinney 1983). 11

FEDERAL AND STATE REGULATIONS:

42 C.F.R. §435.725 ..... 3, 11

42 C.F.R. §435.832 ..... 3, 11

10 NYCRR 86-2.1 *et seq.* 8

OTHER AUTHORITIES:

41 Fed. Reg. 27,300 (1976) 10

41 Fed. Reg. 27, 303 (1976) 7

No. 85-1763

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1985.

FLORENCE NIGHTINGALE NURSING HOME,

Petitioner,

against

CESAR PERALES, Individually and as Commissioner of the New York State Department of Social Services, and GEORGE GROSS, Individually and as Administrator/ Commissioner of the New York City Human Resources Administration,

Respondents.

Brief of the New York State Health Facilities Association, Inc.; Connecticut Association of Health Care Facilities, Inc.; and American Health Care Association, *Amici Curiae,* In Support Of Petition For A Writ of Certiorari to the United States Court of Appeals for the Second Circuit.

STATEMENT OF INTEREST.

This *amicus curiae* brief is submitted on behalf of the New York State Health Facilities Association, Inc.

(NYSHFA)*, the Connecticut Association of Health Care Facilities, Inc. (CAHCF) and the American Health Care Association (AHCA) in support of the Petition for a Writ of Certiorari herein. All the parties to this litigation have been advised of *amici's* intent to file this brief and have indicated they have no objection to its submission.

NYSHFA is a not-for-profit organization whose membership consists of over 200 health care providers throughout the State of New York. These institutions render "skilled nursing facility" or "intermediate care facility services" as defined in the federal Medicaid Act (42 USC §1396 *et seq.*) to some 30,000 sick and mostly elderly patients. Approximately 70% of these patients are Medicaid recipients.

CAHCF is the Connecticut counterpart to NYSHFA. It represents approximately 170 facilities serving a total of 18,375 skilled nursing and intermediate care facility patients. Approximately 65-70% of those patients are Medicaid recipients. These facilities, like those in New York, are within the jurisdiction of the Second Circuit Court of Appeals, and are affected by the decision below.

AHCA, headquartered in Washington, D.C., is the national association of health care facilities with whom both NYSHFA and CAHCF are affiliated. It represents a broad spectrum of over 9,000 private, religious and charitable skilled nursing and intermediate care facilities throughout the United States, serving approximately 850,000 patients, a significant percentage of whom (the exact amount is unknown) are Medicaid recipients.

*As a not-for-profit corporation NYSHFA has no stock. It is, however, the sole stockholder of a subsidiary for-profit corporation, the New York State Health Facilities Service Corporation. It has no parents or other affiliates.

Amici, NYSHFA, CAHCF, and AHCA, all have a significant interest in the outcome of this litigation because of the broad participation by their membership in the Medicaid program. The issue in this case is whether or not any state may force facilities participating in the program within its borders to collect a portion of the rates federal law says the states must pay them from the impoverished, sick and elderly patients they serve.

Below, the State of New York argued that if a facility is unable to collect that portion (known as "NAMI"*) from the patients, the facility is not entitled to receive it from the State, despite the fact that the State has itself determined that these amounts are necessary for the facility to ensure the provision of quality care.

The State has acknowledged that for fiscal year 1983-1984 alone, the NAMI portion owed to facilities amounts to nearly $300 million.** Since a survey of NYSHFA facilities showed that approximately two percent of NAMIs were uncollectible in 1985, approximately six million dollars owed to long-term care facilities for the care of Medicaid patients will be left unpaid within New York State alone if the Second Circuit decision is allowed to stand.***

---

*NAMI is an acronym for "net available monthly income". That refers to the amount, which varies from patient to patient, which the State determines an eligible recipient or his family is responsible for when he/she is determined to be eligible for Medicaid. 42 CRF §§435.725, 435.832.

**See Petition for Certiorari at 9, fn 4.

***This figure is based on the response by 86 member facilities to a May 1986 survey conducted by NYSHFA. No similar survey was conducted by the other *amici.* Although exact figures are therefore unavailable, the amount nationwide must obviously be considerably greater.

Amici strongly concur with the Petitioner that Congress never intended that facilities participating in the Medicaid program were to be ultimately responsible for collecting reimbursement from the many poor patients they serve. Medicaid reimbursement to facilities is and was at all times relevant hereto the sole responsibility of the states. If allowed to stand, the Second Circuit's decision will require NYSHFA's and CAHCF's members to assume that financial risk. Moreover, if followed by courts outside the Second Circuit, it will affect the membership of AHCA as well.

Assumption of that risk is not only onerous but is particularly unfair. The Medicaid Act gives facilities no control over the eligibility determinations states make. The significance of this has assumed even greater proportions for NYSHFA because facilities in many New York locations are now being required to admit a specified percentage of Medicaid patients in order to meet the "public need" requirement for construction or "establishment" approval by the Public Health Council of the State Health Department. New York Public Health Law § 2801-a.3 (McKinney 1985). The Health Department considers the number of Medicaid patients admitted as an indicator of public need for such approvals, and it is considering support for legislation or regulation to require all facilities to accept a certain percentage of Medicaid patients.* It is grossly unfair that facilities in New York be required by the State to accept Medicaid patients, if they are to receive no assurance of payment from the State as a result of the decision below.

---

*Office of Health Systems Management, New York State Department of Health, Draft Report "Assuring Access of Medicaid Patients To Residential Health Care Facilities in New York State" April, 1986, and Minutes of Public Health Council meeting of April 18, 1986 pgs. 7-14.

SUMMARY OF ARGUMENT.

This case affects every hospital, skilled nursing and intermediate care facility in the country which participates in the Medicaid program. Illegally shifting the cost of a legislatively enacted social program onto providers dramatically reduces the amount of reimbursement these facilities will receive despite the fact that the states themselves have determined those amounts to be necessary to the facilities in order to provide adequate quality care.

The decision could, as well, precipitate substantial withdrawals by such institutions from the Medicaid program nationwide. This was precisely what Congress sought to avoid when it first enacted the present cost-based reimbursement methodology for nursing homes and intermediate care facilities in 1972. 42 U.S.C. §1396a(a)(13)(E)*; P.L. 92-603 §249.

The decision below was wrong. The Second Circuit confused the Medicaid law and regulations governing the establishment and payment of rates under 42 U.S.C. §1396a (a)(13)(A)—the responsibility for which rests solely with the states—with the Medicaid laws and regulations governing the financial eligibility of recipients under 42 U.S.C. §1396a(a)(17). The eligibility and reimbursement laws and regulations were, until this decision, separate and

---

*Subparagraph (E) was amended in 1980, P.L. 96-499, §962(a), changing the standard from "cost-related" reimbursement to a standard requiring that reimbursement be sufficient to cover the costs of economically and efficiently operated facilities in order to insure that they will be able to provide quality care. By Public Law 97-35, §725, subparagraph (E) was relettered to subparagraph (A) as it appears in the present law. All parties agree that these changes have no effect upon the issue presented herein.

distinct. The court's merger of the two and failure to read them *in pari materia* has resulted in a clearly erroneous decision. It has shifted onto providers the responsibility for collecting significant amounts of reimbursement from the recipients themselves even though the facilities have no "legal say" under the Medicaid laws in determining Medicaid eligibility—which is the sole responsibility of the states. 42 U.S.C. §1396a(a)(5).

The Second Circuit decision not only reverses two different decisions by the District Court in this matter but is also inconsistent with the only other Circuit Court of Appeals decision on this issue. *Seneca Nursing Home v. Secretary of Social and Rehabilitation Services,* 604 F.2d 1309 (10th Cir. 1979). To clarify confusion in the Circuits on this issue and to correct an erroneous Second Circuit decision of nationwide impact, the Petition for Writ of Certiorari should be granted.

ARGUMENT.

I. This Case Could Have Profound National Implications For The Medicaid Program.

This case will be closely watched throughout the country. Its significance is perhaps best reflected by the fact that the U.S. Government sought and obtained permission from the Second Circuit Court of Appeals to file an *amicus* brief in this matter below.

If the decision is allowed to stand, other states will most surely be tempted to emulate New York's example and shift all financial responsibility for payment of NAMI's onto the facilities themselves. It could also induce many providers to withdraw their participation in the pro-

gram—a result Congess desperately sought to avoid when it first enacted the cost-based reimbursement methodology. 41 Fed. Reg., 27,303 (1976). *DeGregorio v. O'Bannon,* 500 F. Supp. 541, 543-545 (D.C., E.D. Pa. 1980). What, then, will happen to all the patients in such facilities? They have no right to remain in facilities which withdraw from the program. *O'Bannon v. Town Court Nursing Center,* 447 U.S. 773 (1980). *Roberson v. Wood,* 500 F. Supp. 854 (D.C., S.D. Ill. 1980).

The result could be the *de facto* destruction of an important social program designed to provide access to health care for millions of elderly Americans who otherwise could not afford it. This comes at the very time the State of New York has expressed its great concern at the difficulty Medicaid patients already encounter in obtaining access to nursing homes.* At the very least, the Second Circuit's decision will unfairly burden many facilities by shifting permanently onto them a cost that logically and legally should be borne by Government rather than the private sector. The total fiscal impact of the decision cannot be assessed, but based upon the State's own estimates within New York alone,** the nationwide repercussions are enormous.

---

*Office of Health Systems Management, New York State Department of Health, Draft Report "Assuring Access of Medicaid Patients To Residential Health Care Facilities in New York State" April, 1986, p. 1 and Minutes of Public Health Council meeting of April 18, 1986, pgs. 7-14.

**See Petition for Certiorari at 9 fn 4.

II. The Decision Of The Circuit Court Was Erroneous.

A. The Court Misapprehended The Distinction Between "Rates" And "Costs".

The heart of the Second Circuit's opinion can be found in the following language:

> The District Court determined that the statute "clearly calls for a cost-based reimbursement program." 570 F. Supp. at 288. But the District Court did not reckon with the fact that "reasonable cost basis" applies only to the cost of "services provided under the plan." In authorizing reimbursement of providers for Medicaid care costs Congress clearly intended *not* to reimburse for costs not covered by Medicaid. NAMI represents the amount that a patient is required to contribute toward his or her care. This contribution reduces the amount that the patient is eligible to have paid on his or her behalf under the Medicaid program. (Emphasis supplied.)

Petition for Cert. at A-4.

This excerpt from the Second Circuit's opinion reveals the fundamental error in its analysis as well as a lack of understanding of the Medicaid rate-setting process. The *rate* facilities are entitled to be paid is determined by the State totally without regard to the NAMI. It is a function of *costs* already determined by the State's methodology*

---

*In New York State, that methodology is set forth in regulations. 10 NYCRR 86-2.1 *et seq.* Those regulations, approved by the Secretary of Health and Human Services, say absolutely nothing about the NAMI.

which the U.S. Secretary of Health and Human Services has already found to be "satisfactory." 42 USC §1396a(a)(13)(A). The Medicaid reimbursement rate in New York State is determined completely independently of the NAMI. One has nothing to do with the other.

The rate is determined by the costs incurred in providing the service, not by who pays for it. It costs no more or less to provide Medicaid services to a patient who does or does not pay a NAMI. The amount of the NAMI does not reduce the rate the facility is entitled to be paid for services rendered under the program. The NAMI never entered into the rate calculation process to begin with and was never a "cost" as erroneously assumed by the Circuit Court. Since it was not a cost that entered into the rate, it is clearly wrong to deduct it from the rate for services rendered.

Once the Second Circuit made this erroneous "linkage" between the costs involved in calculating the rate and the NAMI, the wrong conclusion it reached was inevitable.

B. The Court Improperly Confused Those Portions of The Law Dealing with Rates With Those Dealing With Eligibility.

In confusing NAMI's with rate setting, the Second Circuit lost sight of the central purpose behind the Medicaid program and the role facilities play in it. The whole point of 42 USC §1396a(a)(13)(A) was to make sure that the facilities were paid for the costs they incurred in efficiently and economically providing quality care. In order to encourage their participation in the program, Congress sought to relieve facilities of the worry about receiving payment from individuals who obviously could not have paid for their care.

The courts have long recognized that the cost of nursing care under the Medicaid program is to be shared by the patient, the states and the federal government. See e.g. *James v. Harris,* 499 F. Supp. 594, 597 (D.C., M.D. Ala. 1980). Nowhere is there any indication that this responsibility was to be shifted to the facility. *DeGregorio v. O'Bannon,* 500 F. Supp. 541; 41 Fed. Reg. 27,300 *et seq.* (1976).

The District Court clearly understood the central purpose of the Medicaid program and the providers' role noting the necessity for their receiving payment *in full. Florence Nightingale Nursing Home v. Blum,* 570 F. Supp. 285, 289, fn 2. The Tenth Circuit also understood this in *Seneca Nursing Home v. Secretary of Social and Rehabilitation Services, supra* at 1311.

Those parts of the Medicaid law and regulations dealing with the NAMI and cited by the Second Circuit have absolutely nothing to do with the provider. They relate solely to "eligibility" determinations, an issue between the State and the recipient, not the provider. If a recipient wishes to be covered under the program, he/she has to pay whatever the lawful NAMI portion for that particular patient may be. If he does not, the states cannot require the facility to absorb the loss for services rendered under the program.

Merging eligibility and reimbursement regulations ignores and perverts the intent of Congress. The states are supposed to pay the facility its rate based on costs. Where the states get the money to pay the facility is their problem, not the facility's. In interpreting and reading the various provisions of the Medicaid Act *in pari materia,* the specific requirements for cost-related reimbursement in §1396a(a)(13)(A) mandating payment take precedence

over other general language in the statute. *Children's Memorial Hospital v. Illinois Department of Public Aid,* 562 F. Supp. 165, 171 (D.C., M.D. Ill. 1983).

In *Children's Memorial Hospital, supra,* the court found certain reimbursement limitations in a state Medicaid plan conflicted with the national public interest articulated in subparagraph 13(A) of §1396a(a). There the court also emphasized that courts should not always defer to an administrative agency's self-serving regulations* and statutory interpretations when there are, as here, "compelling indications" that the agency interpretation is wrong. 562 F. Supp. at 170. *Espinoza v. Farah Manufacturing Company,* 414 U.S. 86, 94-95 (1973); *Red Lion Broadcasting Co. v. FCC,* 395 U.S. 367, 381 (1969).

C. The Second Circuit's Decision Unfairly Places The Burden Of Collection On The Providers.

The federal Medicaid Act clearly places the sole responsibility for determining patient eligibility on the state agency responsible for administering a program within a state's border. 42 U.S.C. §1396a(a)(5). New York implements this by placing that responsibility exclusively with the Department of Social Services. New York State Social Services Law, §364, subd. 1(e) (McKinney 1983).

*The Second Circuit's opinion appeared to rely heavily on 42 CFR §§435.725 and 435.832 (1984). Petition for Certiorari at A-5. Those regulations, however, were issued by the Secretary of Health and Human Services to avoid any governmental responsibility for the NAMIs. Since Medicaid is a joint federal-state program, the less the state expends, the less the federal government has to pay as part of its share. 42 U.S.C. §1396b. However, the Secretary's "bootstrapping attempt" by regulation to escape responsibility for payment cannot supersede the overriding obligation placed on the states and the federal government by Congress to pay rates to facilities based on their costs.

Facilities have absolutely no "say" whatsoever as to whom the states approve for financial eligiblity. Nor do they have any jurisdiction, control or administration over the amount of NAMI established for such patient. The states, on the other hand, have enormous resources at their disposal to determine eligibility. Yet, under this decision it is the facility that is forced to assume the financial burden of chasing down that patient's resources. This is particularly onerous in a large state, like New York, with a significant percentage of patients eligible for Medicaid. Frequently these patients are disabled and/or incompetent and it is their relatives who control their resources.* In many cases it is virtually impossible to identify those relatives or locate the whereabouts of their assets.

If the states are to determine how much a patient must contribute toward his/her care, the states are the ones which should collect it, not the providers who give the care but have no control over the financial eligibility determination in the first place. It was never Congress's intent to place this burden upon providers.

III. The Second Circuit's Decision Conflicts With A Decision By The Tenth Circuit.

In *Seneca Nursing Home v. Secretary of Social and Rehabilitation Services,* 604 F.2d 1309 (10th Cir. 1979), a clearly different result was reached from the decision by the Second Circuit in the case at bar. While the Second Circuit took great pains to distinguish *Seneca, supra,* on

*It is neither moral nor realistic to discharge the patients in such cases. They are usually too sick to be discharged and too incompetent to know where their money is. They are the innocent but helpless victims of their families' refusal to turn the NAMI money over to the facilities.

the grounds that the case turned on Kansas law, statutory language in all states is and must be effectively the same insofar as placing the responsibility for determining Medicaid eligibility squarely on the State ageny that administers the program within its borders. 42 U.S.C. §1396a(a)(5). The Tenth Circuit clearly indicated that the Kansas statute, as well as its own holding, was premised on meeting federal statutory guidelines set forth in 42 U.S.C. §1396 *et seq. Seneca, supra* at 1315.

The distinction between Kansas and New York is, therefore, illusory and irrelevant. The key point is that throughout the country, eligibility determinations are to be made in all cases by a state agency. Providers were given assurances by the federal government that they would be paid for the services rendered. After doing so, they should not have to bear the brunt of the patients' refusal to pay amounts which the state determined are necessary to provide quality care.

Confusion will certainly abound throughout the country by virtue of the clearly opposite results reached by the Second Circuit in the case at bar and the decision by the Tenth Circuit in *Seneca, supra.* The court should resolve these inconsistent results and establish a truly uniform national policy as intended by Congress.

CONCLUSION.

The Petition for a Writ of Certiorari should be granted. In addition, because of the significance of this case, the court should receive the views of as many responsible interested parties as possible. Accordingly, NYSHFA, CAHCF, and AHCA should be granted *amici curiae*

status in this case and be permitted to file any further brief as warranted by the grant of certiorari.

Dated: June 24, 1986

Respectfully submitted,

CORNELIUS D. MURRAY, ESQ.
Attorney for the New York State Health Facilities Association; the Connecticut Association of Health Care Facilities, Inc.; and the American Health Care Association, *Amici Curiae*
Office and P. O. Address
100 State Street
Albany, NY 12207
Tel. (518) 462-5601

SARAH W. BIRN, ESQ.
O'Connell and Aronowitz
Office and P. O. Address
100 State Street
Albany, NY 12207
Tel. (518) 462-5601

Of Counsel